Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42501

Tuneff, Michael J
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Jordan Tuneff
2. Date of Death (Month, Day, Year): December 25, 2001
3. Time of Death: 1510 M
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 215-32-5026
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 21, 1934
9. Birthplace (State or Foreign Country): Massachusetts

To Be Completed by Funeral Director

Usual Residence of Decedent
10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Goldsboro
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 23884 Bridgetown Road
10f. Zip Code: 21636
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Quality Control Engineer
18b. Kind of Business/Industry: Maryland State Highway
17. Father's Name (First, Middle, Last): Jordan Tuneff
18. Mother's Name (First, Middle, Maiden Surname): Mary Gniecko
19a. Informant's Name/Relationship (Type, Print): Mildred Tuneff spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23884 Bridgetown Road Goldsboro, Maryland 21636
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greensboro Cemetery
Date: Dec 29, 2001
20c. Location - City or Town, State: Greensboro, Maryland
21. Signature of Funeral Service Licensee: Thomas K. Helfenbein
22. Name and Address of Facility: Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Vascular Accident	≈5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Atrial Fibrillation	≈5 yrs
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Systemic Lupus Erythematosis
Lung Cancer

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: C Rubio MD
29c. License number: D0052856
29d. Date signed (Month, Day, Year): 12/26/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia F. Rubio, MD 2 Martin Court Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42502

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Thurl Edgar Turner
2. Date of Deeth — Month: December Day: 25, Year: 2001
3. Time of Daeth: 2:10 P.M.
4e. Facility Neme *(If not Institution, give street end number)*: Cumberland Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Deeth: Allegany

Funeral Director

5. Social Security Number: 212-18-1932
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. lest birthday)*: 81 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: Sept 5,1920
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Dacedant

10e. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 115 Oak St.
10f. Zip Code: 21502
10g. Citizen of Whet Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indien, Black, White, etc. *Specify:* White
15. Decedent's Educetion *(Specify only highest grade completed)* — Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+): 2
16a. Dacedant's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Postal System
17. Fether's Neme *(First, Middle, Lest)*: Edgar Alfonso Turner
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Ethel (Freeland)
19e. Informant's Name/Relationship *(Type, Print)*: Timothy Turner / son
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 826 Mt. Royal Ave., Cumberland, MD 21502
20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Sunset Memorial Park
Dete: 12/28/01
20c. Location - City or Town, Stete: Cumberland, MD
21. Signature of Funeral Service Licensee: Robert C. Adams
22. Name end Address of Feciliy: Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or haart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): a. MYOCARDIAL INFARCTION — 5 minutes

Due to (or es e consaquence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest:
b.
Dua to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other eignificant conditions** contributing to deeth but not resulting in the underlying ceusa given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara eutopsy findings available prior to complation of ceusa of daath? 1 [ ] Yes 2 [ ] No

25. Was case refarred to madical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurrad
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Spacify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowladga, daath occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: William Lamm
29c. License number: D 25406
29d. Dete signed *(Month, Dey, Yeer)*: DECEMBER 26, 2001

30. Nema and addrass of person who complated causa of daath (Item 23a) (Type, Print): William Lamm, MD 47 Virginia Ave., Cumberland, MD 21502

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 27 2001
32. Registrer's Signature: Jenna D Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6mell

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42503

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Keith Lowell Taylor

2. Date of Death (Month, Day, Year): December 20, 2001

3. Time of Death: 01:05 A.M.

4e. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 233-50-3048

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 29, 1935

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: WV

10b. County: Hampshire

10c. City, Town or Location: Romney

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 542 Central Ave.

10f. Zip Code: 26757

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-55

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Captain

16b. Kind of Business/Industry: West Virginia Dept. Natural Resources

17. Father's Name (First, Middle, Last): John Taylor

18. Mother's Name (First, Middle, Maiden Surname): Nannie Hortense (Plauger)

19a. Informant's Name/Relationship (Type, Print): Lucy Smith Taylor / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 542 Central Ave., Romney, WV 26757

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Maple Hill Cemetery

Date: 12/22/01

20c. Location - City or Town, State: Petersburg, WV

21. Signature of Funeral Service Licensee: Robert C. Adams Jr

22. Name and Address of Facility: Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	COR PULMONALE	6 mo
Due to (or as a consequence of): b.	CHRONIC OBSTRUCTIVE LUNG DISEASE	18 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE BRONCHITIS

RIGHT HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul J. Livengood MD

29c. License number: D0023774

29d. Date signed (Month, Day, Year): December 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL T. LIVENGOOD MD 912 SETON DR CUMBERLAND MD 21502

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001

32. Registrar's Signature: Jeanne B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2001 42504
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gereather Velazquez			2. DATE OF DEATH (Month, Day, Year): Dec. 16, 2001	3. TIME OF DEATH: 6:45 pm M
4. SOCIAL SECURITY NUMBER: 579-28-1271	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 25, 1918	8. BIRTHPLACE (State or Foreign Country): Laurence, S.C.
9a. FACILITY NAME (If not institution, give street and number): 3436 Brinkley Road #203		9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Temple Hills		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3436 Brinkley Road #203		10f. ZIP CODE: 20748		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Baker		16b. KIND OF BUSINESS/INDUSTRY: Guest Services Inc Food Industry
17. FATHER'S NAME (First, Middle, Last): Lawrence Thompson			18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Wright	
19a. INFORMANT'S NAME (Type/Print): Barbara I. Thompson-Niece		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3407 Pearl Dr. Suitland, Md. 20746		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Fort Lincoln Cemetery DATE: 12/20			20c. LOCATION — City or Town, State: Brentwood, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Francis B. Hunt		22. NAME AND ADDRESS OF FACILITY: Hunt Funeral Home 908 Kennedy St. N.W. Wash. D.C. 20011		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. carcinoma of lung	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Hypothyroidism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D46478	▶ 12-18-01

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Suresh A. Patel MD 7501 Surratts Rd #307. Clinton. MD 20735

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 21 2001	[signature]

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42505

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Hugh Blanchard Vickery	December 14,2001	8:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
10450 Lottsford Rd #2001	Mitchellville	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
002-30-3098	1 [X] M 2 [ ] F	82 Yrs.			Jan 9,1919	Boston, MA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Mitchellville	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10450 Lottsford Rd #2001	20721	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	U.S. Navy	Military

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Howard Leroy Vickery	Marguerite Blanchard Vickery

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Vickery/ Wife	10450 Lottsford Rd #2001 Mitchellville,MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metropolitan Crematory	12/17/2001	20721 Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Beall Funeral Home 6512 NW Crain Hwy Bowie, MD 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute myocardial infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ischemic cardiomyopathy

peripheral vascular disease

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D25079	December 17, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Don H. Yahonowitz, MD 7404 Executive Pl. #502 Lanham,MD 20706

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 18 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42506

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lawrence R. Williams
2. Date of Death (Month, Day, Year): December 11, 2001
3. Time of Death: 12:53 A.M.

4a. Facility Name *(If not institution, give street and number)*: Fort Washington Medical Center
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-86-7577
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 18, 1959
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 10038 Allentown Road
10f. Zip Code: 20744
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineeer
16b. Kind of Business/Industry: U.S. Department Of State

17. Father's Name *(First, Middle, Last)*: Nathaniel Williams
18. Mother's Name *(First, Middle, Maiden Surname)*: Valerie Watson

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Tondelayo V. Williams (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10038 Allentown Road Fort Washington, Maryland 20744

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory, Inc.
Date: 12/24/01
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Janet C. Anderson
22. Name and Address of Facility: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sarcoidosis — 19 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hemoptesis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Phong Nguyen MD
29c. License number: VA 0101 043746
29d. Date signed *(Month, Day, Year)*: Dec 14, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 12011 Lee Jackson Hwy, Fairfax, VA 22033-3310

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 2001
32. Registrar's Signature: S. Jones

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 2 0 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42507

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Estella L. Walden	DECEMBER 14, 2001	1:20 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctor's Community Hospital	Lanham	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
419-70-2909	1☐M 2☒F	50 Yrs.			03-26-1951	Alabama

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Mitchellville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10302 Cleary Lane	20721	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2yrs.	Secretary	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leroy Coleman	Mary Blackman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Yolanda Wright/ Daughter	604 England Pointe Dr. Fredericksburg, VA 22406

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ft. Lincoln	12-21-01	Brentwood, MD

21. Signature of Funeral Service Licensee: K. D. Marshall

22. Name and Address of Facility: JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac failure	1 hr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Sepsis	7 days
	c. Due to (or as a consequence of): Peripheral Vasular Disease	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Diabetes

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Sanil Nath M.D.	D005107	12/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANIL NATH 14300 GALLANT FOX LANE SUITE 205 BOWIE MD 20705

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 19 2001	Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GR WALDEN, ESTELLA

(4)

DEC 18 2001

Adrian W. Walker
CJ
01-7220-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 021302:ITEMS#23a,27 per ME G804 ss

Certificate of Death

Reg. No. 2001 42508

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Adrian W. Walker

2. Date of Death: Month December, Day 19, Year 2001

3. Time of Death: 05:09 P.M.

4a. Facility Name (If not Institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-78-9055

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 43 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 10-22-1958

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: DC

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4202 H St. S.E.

10f. Zip Code: 20019

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Oren Music

17. Father's Name (First, Middle, Last): William E. Walker

18. Mother's Name (First, Middle, Maiden Surname): Charlotte Johnson

19a. Informant's Name/Relationship (Type, Print): Stacy A. Walker (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8645 Greenbelt RD. #T2 Greenbelt, MD 20770

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 12-27-01

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Jeremy A. Thurston

22. Name and Address of Facility: Austin Royster Funeral Home 3821 14th. St. N.W. Washington, D.C. 20011

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DRUG USE ASSOCIATED WITH SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore McKinney

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): December 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE McKINNEY 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

DEC 3 0 2004

Amended # 196, nls, 12/18/01, Allegany Co.

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42509

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Glenn E.	Winters	Jr.	Dec 16, 2001	12:10am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Cumberland Nursing Home	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-34-1666	1☒M 2☐F	66 Yrs.			Mar 27, 1935	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
220 Somerville Ave. Apt 401	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1955-1959	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Bartender	Boonie's Place

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Glenn E. Winters, Sr.	Rosella P Clay

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ronald E. Winters Brother	17 Prides Crossing; Shenandoah Junction, WV 25442

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Mary's Cemetery	12/18 2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James T Scarpelli	Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Renal failure	3 days
Due to (or as a consequence of):	Ca colon with metastases.	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Pete Talmus MD	D0 4981	December 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. HALMOS 302 Schley St. Cumberland, Md 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 18 2001	G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

nls

DHMH 16 Rev 6/95

ORIGINAL

01-7137-005
RION WHEELER
CDT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#23a per ME G804 030102 ss
UNPENDED 011702: ITEMS#23a,27 per ME G803 ss

Certificate of Death

Reg. No. 2001 42510

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RION WHEELER	DECEMBER 18, 2001	530 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL CENTER	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-64-9738	1☒ M 2☐ F	42 Yrs.			MAR 12, 1959	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	CATONSVILLE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24 KIMBALL RIDGE DRIVE	21228	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		CONTRACTOR	CONSTRUCTION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ROBERT EDWIN WHEELER	ESTHER THOMPSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR/MRS ROBERT WHEELER (PARENTS)	1975 MT. VIEW ROAD MARRIOTTSVILLE, MD 21104

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mt. View Cemetery	12/21/01	MARRIOTSVILLE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Brian L. Haight	HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIAC SARCOIDOSIS ~~DILATED CARDIOMYOPATHY~~

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Select only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Aaron Locke, MD	O.C.M.E.	DECEMBER 18, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJ2
1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42511

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MABEL LOVELL WANTZ	December 17 2001	1515 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Lookabout Manor	Westminster	Carroll County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-16-0883	1☐M 2☒F	85 Yrs.			June 11, 1916	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll County	Taneytown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
315 Roberts Mill Road	21787	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, Whita, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		secretary / bookkeeper	business administration

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Earl Lovell	Agnes Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Patricia J. Lawyer/daughter	201 Carroll Heights Road Taneytown, MD 21787

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Pleasant Valley Cem.	Dec. 20 2001	Pleasant Valley, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Alan C. Powers M01072	Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Metastatic colon Cancer

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

Dementia
Peripheral vascular disease
Diabetes mellitus II

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No	28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) assisted living facility

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D33599	12-18-2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
Philip J. Ruzbarsky, M.D. 125 Airport Drive Westminster, MD 21157

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signature
DEC 19 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

WJL 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42512

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Isabel T. Weston	January 01, 2002	9:57 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-22-1793	1☐M 2☒F	83 Yrs.			Jan. 09, 1918	NH

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	University Park	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4220 East-West Highway	20782	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Pasquale Tallarico	Anna Batchelder

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James K. Weston/ son	24 Mallow Hill Rd. Balto.,MD 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bayview Crematory,Inc	Jan.4, 2002	Balto., MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Beverly L. Heckrotte M01251	Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville,MD 21029

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Suresh Khetan	D55403.	01/02/02 at 5:00PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURESH K. KHETAN, MD 7610 CARROLL AVE #200, TAKOMA PARK, MD 20912

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 04 2002	▶ Jeanne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(15)

CGJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42513

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARSHALL ELWOOD WILSON, SR.

2. Date of Death Month Dey Year: DECEMBER 6, 2001

3. Time of Death: 12:20AM M

4a. Facility Name (If not institution, give street and number): ST VINCENT DE PAUL NURSING CENTER

4b. City, Town, or Location of Death: FROSTBURG, MARYLAND

4c. County of Death: ALLEGANY COUNTY

Funeral Director

5. Social Security Number: 213-10-1983

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 17 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: Allegany

10c. City, Town or Location: Westernport

10d. Inside City Limits: ☒Yes 2☐No

10e. Street and Number: 205 Quality St.

10f. Zip Code: 21562

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): unknown

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Station owner

18b. Kind of Business/Industry: gas, oil, auto

17. Father's Name (First, Middle, Last): John Wilson

18. Mother's Name (First, Middle, Maiden Surname): Louise Hollar

19a. Informant's Name/Relationship (Type, Print): Marshall E. Wilson Jr./ son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 210 Quality St., Westernport, Maryland 21562

20a. Method of Disposition: ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Philos Cemetery

Date: 12/08/2001

20c. Location - City or Town, State: Westernport, Maryland

21. Signature of Funeral Service Licensee: ▶ F. Wayne Boal

22. Name and Address of Facility: Boal Funeral Home 111 Church St., Westernport, Md. 21562

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RENAL FAILURE — 7 DAYS

Due to (or as a consequence of):

b. CHRONIC RENAL FAILURE — 4 MOS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. DIABETIC NEPHROPATHY — 4 MOS

Due to (or as a consequence of):

d. DIABETES MELLITUS — 24 YRS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Dey Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC CONGESTIVE HEART FAILURE

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robustiano J. Barrera, Jr.

29c. License number: D-14865

29d. Date signed (Month, Day, Year): DEC. 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): Dr. Robustiano Barrera, Memorial Hospital Medical, Cumberland, Md. 21502

State Registrar

31. Date filed (Month, Day, Year): DEC - 7 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 42514

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Ware

2. Date of Death (Month, Day, Year): December 13, 2001

3. Time of Death: 10:45 AM

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 220-03-1357

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 19, 1920

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Queen Ann

10c. City, Town or Location: Barclay

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1312 Goldsboro Road

10f. Zip Code: 21607

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11-grad

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Fred M. Stafford

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Bradley

19a. Informant's Name/Relationship (Type, Print): Mark Crossley/ grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4201 Fairmont Pkw. Apt 301 Pasadena, TX 77504

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greensboro Cemetery

Date: Dec 16, 2001

20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Service Licensee: Steve Fleegle

22. Name and Address of Facility: Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Disease / Edema — 7 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction — 10 DAYS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Temporal Arteritis

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christian F. Meyer, MD

29c. License number: P15792

29d. Date signed (Month, Day, Year): 12/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTIAN F. MEYER, MD 22 South Greene St., Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 17 2001

32. Registrar's Signature: Jennie G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended #4a per MD FCHD, KS 12/20 — Certificate of Death — Reg. No. 2001 42515

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
Charlotte	Wiles	December 15, 2001	2:08 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital ~~40 Livingstone Terrace~~	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
017-28-1667	1☐ M 2☒ F	64 Yrs.			March 20, 1937	Massachusetts

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
40 Livingstone Terrace	21702	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Switchboard operator	Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William H. Elliott	Thelma C. Smith

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paula A. Wiles / Daughter	211 4th Avenue Burnswick, Maryland 21716

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removet from Stete 4☐ Donation 5☐ Other (Specify)	Resthaven Mem. Gardens	December 19, 2001	Frederick, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part1. Enter the disease) or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease	Months
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

tF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

23e. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐ **Medicat Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M Tolino MD	MD 51610	12-15-01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
1475 Taney Ave Suite 204 Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 2001	▶ Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

12

RKD

01-7058-021

PATRICIA
WEIER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42516

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA ANN WEIER

2. Date of Death (Month, Day, Year): DECEMBER 14, 2001

3. Time of Death: 4:40P.M.

4a. Facility Name (If not institution, give street and number): 1464 DOCKSIDE COURT

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 530-48-5328

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 23, 1954

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 1464 Dockside Court

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1973-1977

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tax Specialist

16b. Kind of Business/Industry: State Government

17. Father's Name (First, Middle, Last): Jack Damrow

18. Mother's Name (First, Middle, Maiden Surname): Donna Van Dusen

19a. Informant's Name/Relationship (Type, Print): Mrs. Donna Damrow, mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1464 Dockside Ct., Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery, Dec. 18, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Richard E. Graf M00255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dilated Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

26a. Date of Injury (Month, Day, Year)

26b. Time of Injury M

26c. Injury at Work? 1☐ Yes 2☐ No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Pestaner, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

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State Registrar

31. Date filed (Month, Day, Year): DEC 17 2001

32. Registrar's Signature: Denise B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42517

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maude Elizabeth Wehner
2. Date of Death Month Day Year: December 12, 2001
3. Time of Death: 11:15 PM
4a. Facility Name (If not institution, give street and number): 324 Redwood Avenue
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-10-4881
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-06-1903
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 324 Redwood Avenue
10f. Zip Code: 21701
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Hubbard
18. Mother's Name (First, Middle, Maiden Surname): Iola Hurley

19a. Informant's Name/Relationship (Type, Print): Deborah Sier/granddaughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 12364 Liberty E. Terrace, Union Bridge, Maryland 21791

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Spring Hill Mem. Gardens
Date: 12-17-2001
20c. Location - City or Town, State: Salisbury, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Dilated Cardiomyopathy
Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D 26516
29d. Date signed (Month, Day, Year): Dec 13 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen G. Sapp MD 1475 Taney Ave Fred MD 21702

State Registrar

31. Date filed (Month, Day, Year): DEC 17 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42518

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA WILLIAMS

2. Date of Death (Month, Day, Year): December 12, 2001

3. Time of Death: 1:29 P M

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 225-66-3569

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 21, 1946

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6503 Mountaindale Road

10f. Zip Code: 21788

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): nurses aide

16b. Kind of Business/Industry: hospital

17. Father's Name (First, Middle, Last): William Stanley Caylor

18. Mother's Name (First, Middle, Maiden Surname): Lucille Scott Beckham

19a. Informant's Name/Relationship (Type, Print): Jessie Williams / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6503 Mountaindale Rd, Thurmont, MD 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem. Gardens

Date: 12/15/01

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 40 Fulton Ave., Walkersville, MD 21793

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heert failure. List only one ceuse on each line.

Immediate Cause (Finel diseese or condition resulting in death): a. Pulmonary Hypertension — Approximate Interval Between Onset and Death: 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. C.O.P.D — 5 years

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnent et time of death 5☐ Other (specify) 9☐ Unknown

23d. Date ot delivery (Month, Day, Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Sleep Apnea

23e. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D21944

29d. Date signed (Month, Day, Year): 12/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James S. Grisson M.D. 300 W. 9th St. Frederick, Md. 21701

15

State Registrar

31. Date filed (Month, Day, Year): DEC 17 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 42519

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John William Whetzel
2. Date of Death Month Day Year: December 19, 2001
3. Time of Death: 1:15 P.M.

4a Facility Name *(If not institution, give street and number)*: Cumberland Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-30-1568 A
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 9, 1932
9. Birthplace *(State or Foreign Country)*: Cumberland

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12807 Bunting St.
10f. Zip Code: 21502
10g. Citizen of What Country?: United States

11. Meritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Printer
16b. Kind of Business/Industry: Newspaper

17. Father's Name *(First, Middle, Last)*: John Macard Whetzel
18. Mother's Name *(First, Middle, Maiden Surneme)*: Lucy Marie (Ballou)

19a. Informant's Name/Relationship *(Type, Print)*: Betty Wheeler / sister
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 402 Woodbrook Ct., Canton, GA 30114

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetery, crematory or other place)*: Hillcrest Burial Park
Dete: 12/22/01
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Robert C. Adams
22. Name and Address of Facility: Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each lina.

		Approximate Interval Between Onset end Death
Immediate Cause (Final diseese or condition resulting in death) a.	Ischaemic cardiomyopathy	6 months
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest b.		
Due to (or as e consequenca of):		
c.		
Due to (or as a consequenca of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.: Renal failure. Jaundice

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy tindings available prior to completion ot cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place ot Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: Peter Holmes MD
29c. License number: D0 49881
29d. Date signed *(Month, Day, Year)*: December 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. HALMES 302 Schley st. Cumberland, Md 21502

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Amend Items 1,24a,25,29c,29d per Physician 12/19/2001 Carroll County, wjl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42520

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~ZELTMAN, Joyce~~ JOYCE ZELTMAN
2. Date of Death Month 12 Day 16 Year 01
3. Time of Death 0600 A M
4a. Facility Name (If not institution, give street and number): Shock-Trauma
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 305-52-7023
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 4, 1948
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Hanover
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 12 Chesapeake Mobile Court
10f. Zip Code: 21076
10g. Citizen of Whel Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12); College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses Aide
18b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Unknown Kincade
18. Mother's Name (First, Middle, Maiden Surneme): Leona Clark

19a. Informant's Name/Relationship (Type, Print): Mr. Robert A. Zeltman (Spouse)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 12 Chesapeake Mobile Ct. Hanover, MD 21076

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removat from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Lake View Mem. Park
Date: 12/19/01
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410) 795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)
a. Sepsis
Due to (or as e consequence of):
b. Necrotizing Fasciitis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initieted events resulting in death) Last
c.
Due to (or as a consequence of):
d.

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date ot delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Staff Physician
29c. License number: ~~S 12436~~ P13990
29d. Date signed (Month, Day, Year): ~~12/14/01~~ 12/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC G. SHAW 107 Glenmore Ave CATONSVILLE, MD 21228

State Registrar

31. Date filed (Month, Day, Year): DEC 19 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended#23(b)perMD FCHD,KS

Certificate of Death

Reg. No. 2001 42521

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD H. ZINER

2. Date of Death (Month, Day, Year): DEC. 17 2001

3. Time of Death: 7:40 AM

4a. Facility Name (If not institution, give street and number): 2107 WALSH VIEW TERR. #201

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-44-3872

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 25 1932

9. Birthplace (State or Foreign Country): WASH., DC

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2107 WALSH VIEW TERR. #201

10f. Zip Code: 20902

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUSINESS OWNER

18b. Kind of Business/Industry: SPRING WORKS CO.

17. Father's Name (First, Middle, Last): MARTIN ZINER

18. Mother's Name (First, Middle, Maiden Surname): ANNA PISKADLO

19a. Informant's Name/Relationship (Type, Print): MARK ZINER / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19715 SELBY AVE., POOLESVILLE, MD 20837

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMET.

Date: 12/20

20c. Location - City or Town, State: SUITLAND, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HILTON FUNERAL HOME BOX 86, BARNESVILLE, MD 20838

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ADENOCARCINOMA OF THE COLON — 1998

Due to (or as a consequence of):
b. Metastatic to liver & lungs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D06959

29d. Date signed (Month, Day, Year): DECEMBER 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELSA J. MARTINEZ MD — 8808 HUDDEN HILL LANE - POTOMAC, MD. 20854

3

State Registrar

31. Date filed (Month, Day, Year): DEC 20 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42522

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Charles Zimmerman	December 14, 2001	5:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6898 Arbor Court	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-10-2541	XX 1 M 2 F	89 Yrs.			Sept. 4, 1912	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6898 Arbor Court	21703	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married XX 2 Married 3 Widowed 4 Divorced	XX 1 Yes 2 No If Yes, Give Year or Dates:	1 Yes XX 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Installer/ Repair Man	C & P Telephone Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Edgar Zimmerman	Wilma Trout

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Mercer Zimmerman, wife	6898 Arbor Court Frederick, Maryland 21703

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial XX 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Hagerstown Crematory	12/15/01	Hagerstown, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pancreatic Cancer	6 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DM II

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XX No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 XX No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 XX No

28. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 XX Residence 8 Other (Specify)

27. Manner of Death 1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Martin Pierce MD	D46249	12/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin Pierce, MD 300 W. 9th Street Frederick MD 21701

10+1

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 17 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42523

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JAMES ADAMS JR.	December 27, 2001	1:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Bon Seccour Hospital	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-64-0656	1☒M 2☐F	46 Yrs.			12 31 54	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
223 N. Calhoun Street	21223	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th grade		Custodian	Social Security

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Adams Sr.	Pauline Richardson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pauline Travers Mother	9 N. Wolfe Street Baltimore Maryland 21231

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT Carmel	1-2-02	Dundalk , Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Conrad L. McFadden	Baltimore, Maryland 21202 March F.H. East 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic Encephalopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Acquired Immuno defeciency Syrdrome

Due to (or as a consequence of):

c. Hepatitis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kosita R. Cruz M.D	D0030355	December 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kosita R. CRUZ M-D BON SECOURS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2002	▶ D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42524

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAROLD ARTIS

2. Date of Death (Month, Day, Year): December 24th 2001

3. Time of Death: 1102 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 240-54-8795

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Yaer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): 4-7-36

9. Birthplaca (State or Foraign Country): N CARDINA

Usual Residance of Decedant

10a. Stete: MARYland

10b. County: BALTIMORE

10c. City, Town or Location: PIKESVILLE

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 117 CourtLand Woods DRIVE

10f. Zip Code: 21208

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Merried 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒Yas 2☐No If Yas, Give Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 1☐Yes 2☒No Specify:

14. Race - Amaricen Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 11 grade; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): CHEF

16b. Kind of Businass/Industry: LINDA'S CAFE

17. Fether's Name (First, Middle, Last): ALEX BROWN

18. Mother's Nama (First, Middle, Maidan Surnama): MAMIE ARTIS

19a. Informant's Name/Ralationship (Type, Print): JOYCE ARTIS - WIFE

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 117 CourtLand Woods DRIVE PIKESVILLE Md 21208

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Nama of cemetary, cramatory or othar place): GARRISON FOREST VET. CEM.

Data: 1/2/02

20c. Location - City or Town, Stata: OWINGS MILL, Md

21. Signatura of Funaral Sarvice Licensee: ▶ Eurodias E Parker

22. Nama and Address of Facility: KEVIN A PARKER Funeral Home PA 3512 Frederick Ave Balto, Md 21229

Physician /Medical Examiner

23a. Part I. Entar tha disaase, or complications that ceusad tha daath. Do not anter the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onset end Deeth

Immediate Ceuse (Finei disease or condition resulting in daath)

a. Myocardial Infarction — 4-5 mths

Dua to (or as a consequance of):

Sequantially list conditions, if eny, leading to immediata ceusa. Entar Underlying Causa (Disaase or Injury that initiated avants resulting in death) Last

b. Arteriosclerotic Disease — several mths

Dua to (or as a consequanca of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

Diabetes

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performad? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐Yas 2☒No

25. Was cesa rafarred to medical examinar? 1☐Yes 2☒No

26. Placa of Daath (Check only ona)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Othar: 4☐Nursing Home 5☐Residance 6☐Othar (Specify)

27. Mannar of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding investigation 6☐Could not be datarmined

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28b. Tima of Injury: M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: ▶ William Jaquis, MD

29c. Licansa number: D57429

29d. Data signed (Month, Day, Yaar): JANUARY 7, 2002

30. Nama and addrass of parson who completad ceusa of daath (Item 23a) (Type, Print): WILLIAM JAQUIS SINAI HOSPITAL 2401 W. BELVEDERE BALTIMORE

State Registrar

31. Date filed (Month, Day, Yaar): JAN 0 8 2002

32. Registrar's Signatura: ▶ Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Harold Artis

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42525

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Coleman M. Boyd
2. Date of Death Month / Day / Year: December 7, 2001
3. Time of Death: 0815 A M
4a. Facility Name (If not institution, give street and number): Maryland Community Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-14-9235
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 25, 1924
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5338 Wright Avenue
10f. Zip Code: 21205
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: Navy WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sheet Metal Worker
16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): Russell Boyd
18. Mother's Name (First, Middle, Maiden Surname): Pebble Wattley

19a. Informant's Name/Relationship (Type, Print): Nancy Boyd / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5338 Wright Ave. Baltimore MD 21205

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation
Date: 12-7-01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ANATOMIC GIFT FOUNDATION 13948 Baltimore Ave. Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Non Hodgkins Lymphoma.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: 13-11235.
29d. Date signed (Month, Day, Year): 12-31-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger HAKimiam - VA Medical Center, Green St, Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 11

1- For State Registrar PER FH G803 01/08/02 RR

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 42526

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNARD BRANTNER

2. Date of Death (Month, Day, Year): DECEMBER 31 2001

3. Time of Death: 10:15 AM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 171 48 3817

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 6 1955

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: PA

10b. County: Bedford

10c. City, Town or Location: Breezewood

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 191 Dell Road

10f. Zip Code: 15533

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): diesel mechanic

16b. Kind of Business/Industry: trucking

17. Father's Name (First, Middle, Last): Bernard B. Brantner, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Lillie Mae Costigan

19a. Informant's Name/Relationship (Type, Print): Ronald Brantner brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 Old Quaker Rd Lewisberry, Pa 17339

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Grove Mem Park

Date: Jan 4 2002

20c. Location - City or Town, State: E. Providence Twp, Pa

21. Signature of Funeral Service Licensee: Krista J. Wells

22. Name and Address of Facility: Baltimore, MD 21234, EVANS FUNERAL CHAPEL 8800 HARFORD RD.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. LIVER FAILURE — Approximate Interval Between Onset and Death: 2 Months

Due to (or as a consequence of):
b. CIRRHOSIS — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James C Lee

29c. License number: RES-000

29d. Date signed (Month, Day, Year): DECEMBER 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES C LEE, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE MARYLAND 21287

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

RR

RR 24

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002

32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — 2001 42527

Certificate of Death

1- For State Registrar: AMEND ITEMS #8,24a,25,26&27 PER PHY JH — Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY · C. BOWEN
2. Date of Death Month Dec Day 25 Year 2001
3. Time of Death 11:25 AM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 215-05-9967
6. Sex 1☑M 2☐F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-1-1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits 1☐Yes 2☑No
10e. Street and Number: 8720 Ridge RD #317
10f. Zip Code: 21043
10g. Citizen of What Country? USA

11. Marital Status 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☑Yes 2☐No If Yes, Give Year or Dates: 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Independent Contractor
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Harry C. Bowen, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Lillian M. Mosley

19a. Informant's Name/Relationship (Type, Print): Elizabeth Anna Bowen/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8720 Ridge RD #317 Ellicott City, MD 21043

20a. Method of Disposition 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Mem. Garden — Date: 12/29/2001
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: John Black
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	METASTATIC PROSTATE CANCER	≈MANY YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	ACUTE RENAL FAILURE	2 DAYS
Due to (or as a consequence of): c.	HEPATIC ENCEPHALOPATHY	2 DAYS
Due to (or as a consequence of): d.		

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetef death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24e. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D0053987
29d. Date signed (Month, Day, Year): DEC 25-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KENNETH GEH, M.D; Little Patuxent Pkwy #10840, Columia MD 21044 Suite 302

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2002
32. Registrar's Signature: Donna O Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42528

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances M. Blottenberger
2. Date of Death: Month December Day 31 Year 2001
3. Time of Death: 2:00 P. M
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-34-9922
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct, 7, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Gambrills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2108 Autumn Haze Court
10f. Zip Code: 21054
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse Assistant
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): John J. Blottenberger
18. Mother's Name (First, Middle, Maiden Surname): Anna M. Carlisle

19a. Informant's Name/Relationship (Type, Print): Joann P. Eyler - Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2108 Autumn Haze Court, Gambrills, MD 21054

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem. Park
Date: Jan 4, 2002
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Paul W. Hagan
22. Name and Address of Facility: Singleton Funeral Home, P.A. 1 Second Ave. S.W. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Aspiration Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Seizures
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): December 31 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Angela Dhanraj, 301 Hospital Drive, Glen Burnie, MD. 21061.

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

FRANCES BLOTTENBERGER

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AME ND ITEM #29d PER PHY G803 1/08/02 JH

Certificate of Death

Reg. No. 2001 42529

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
EARL B. CREHAN, SR	DECEMBER 16 2001	09:20A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. AGNES HOSPITAL	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-28-3732	1 [X] M 2 [ ] F	70 Yrs.			NOV. 12, 1931	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	HOWARD	GLENWOOD	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2821 SHADOW ROLL COURT	21738	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952 1955	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		VICE PRESIDENT	WESTINGHOUSE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GEORGE ANTHONY CREHAN	JENNIE LEONARD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY CREHAN-WIFE	2821 SHADOW ROLL COURT, GLENWOOD, MD. 21738

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	LOUDON PARK CENETERY	12-20-01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kim Schlange M0120	WITZKE FUNERAL HOME OF CATONSVILLE, INC 1630 EDMONDSON AVE., CATONSVILLE, MD. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	1 WEEK
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CORONARY ARTERY DISEASE	10 YEARS
	Due to (or as a consequence of): c. HYPERTENSION	40 YEARS
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
B. Anakwa (MEDICAL RESIDENT)	P 15 632	DECEMBER 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. ANAKWA, ST. AGNES HOSPITAL 900 CATON AVE, BALTIMORE MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2002	D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME CREHAN, EARL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42530

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donna Dever

2. Date of Death (Month, Day, Year): December 29 2001

3. Time of Death: 9:12 AM

4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-42-2989

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 6, 1944

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3827 Cassandra Rd.

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Disabled

16b. Kind of Business/Industry: N/A

17. Fathar's Name *(First, Middla, Last)*: unk

18. Mother's Name *(First, Middle, Maiden Surname)*: Claretta Douglass

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Claretta Street (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2978 Bero Rd. Balto. Md. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion

Date: 1/11/2002

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: ▶ Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not anter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on aach line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseasa or condition resulting in death) a.	Acute multiple organ system failure	3 hours
Due to (or as a consequence of): b.	Systemic inflammatory response syndrome	>3 hours
Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequance of): c.	Acute intraabdominal hypertension	>3 hours
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: bipolar disorder; hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end placa, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J Boston MD

29c. License number: D28462

29d. Date signed *(Month, Day, Year)*: December 29, 2001

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): J Boston Northwest Hospital Center Randallstown, Maryland 21133

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2002

32. Registrar's Signatura: ▶ Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#19b per informant G805 032802 ss

Certificate of Death

Reg. No. 2001 42531

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael Leo DiRende

2. Data of Death Month Day Year: November 20, 2001

3. Time of Death: 4:30PM

4a Facility Name *(If not institution, give street end number)*: Sinai Hebrew Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 146 44 5571

8. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 51 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Sept 20 1950

9. Birthplace *(State or Foraign Country)*: Connecticut

Usual Residance of Decedent

10a. Stete: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5608 April Journey

10f. Zip Coda: 21044

10g. Citizen of What Country?: USA

11. Marifal Stetus: 1 ☐ Navar Marriad 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Detas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elamentary/Secondary (0-12): College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Early Childhood Educator

16b. Kind of Business/Industry: Nursery School

17. Fathar's Nama *(First, Middla, Last)*: Joseph DiRende

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Anita Chiesa

19a. Informant's Name/Relationship *(Type, Print)*: Amy Lynn DiRende / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 13203 Astoria Hill Court, apt. I, Germantown, MD 20874-3987 ~~5608 April Journey Columbia, Maryland 21044~~

20a. Mathod of Disposition: 1 ☐ Buriel 2 ☒ Cramation 3 ☐ Ramaval from Stata 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: National Crematory

Date: 11/30/01

20c. Location - City or Town, Stata: Falls Church, Virginia

21. Signeture of Funarel Service Licensee ▶

22. Name and Address of Facility: Affordable Funeral Services P.O. Box 542 Merrifield, Virginia 22116

Physician /Medical Examiner

23e. Pert1. Enter tha disaasa, or complications that caused tha deeth. Do not antar tha mode of dying, such es cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Betwaan Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. Sepsis — Days

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaasa or injury that initieted avants rasulting in daath) Last

b.

Dua to (or as e consequanca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: Endstage Renal Disease, Antiphospholipid Antibdy Syndrome

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was en autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☒ No

25. Wes casa rafarred to medical exeminar? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only ona)*: Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Residanca 6 ☐ Othar *(Specify)*

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 ☑ **Certifying Physician:** To tha best of my knowledge, deeth occurred at tha time, date and placa, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, data and placa, and due to the cause(s) and mannar stated.

29b. Signatura and tita of cartifiar ▶ Raymond Miller MD

29c. Licansa number: D47683

29d. Data signed *(Month, Day, Year)*: November 20, 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Dr. Raymond Miller, 25 Main St. #200, Reisterstown, MD 21136

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 0 8 2002

32. Registrar's Signatura ▶ Jennifer D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-7392-510

KEMARA FOUNTAIN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 012402: ITEMS #23,27 per ME G803 ss

Certificate of Death

Reg. No. 2001 42532

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
KEMARA FOUNTAIN	DECEMBER 31, 2001	8:33P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GOOD SAMARITAN HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-63-2811	1☐ M 2☒ F	Yrs.	1 / 11		11-20-2001	MARYLAND

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1408 LOCHNER RD, APT D	21239	USA

11. Meritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)	14. Race - American Indien, Black, White, etc.
1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0	0	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
KENDERRICK FOUNTAIN	SHIRMA KNOTT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SHIRMA KNOTT, MOTHER	1408 LOCHNER RD, APT.D. BALTO. MD 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MOUNT ZION CEMETERY	01-10-02	MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Willie E Howell	HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO.MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	O.C.M.E.	JANUARY 1,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2002	▶ [signature] B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42533

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNIS FIELDER

2. Date of Death Month 12 Day 31 Year 2001

3. Time of Death 7:20 P M

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 289-40-8985

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 17, 1943

9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 443 ELLWELL COURT

10f. Zip Code: 21061

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REGISTERED NURSE

16b. Kind of Business/Industry: MEDICAL

17. Father's Name (First, Middle, Last): EMORY P. LARSEN

18. Mother's Name (First, Middle, Maiden Surname): HELEN SLOUGH

19a. Informant's Name/Relationship (Type, Print): KENDALL FIELDER (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 443 ELLWELL COURT, GLEN BURNIE, MARYLAND 21061

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): NEW MAPLEWOOD CEMETERY Date: 1/5/2002

20c. Location - City or Town, State: NORTH BALTIMORE, OHIO

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST — 1 hour D.

Due to (or as a consequence of):

b. HTN, CAD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D30714

29d. Date signed (Month, Day, Year): 01-02-2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J Jackson 2003 Medical Pkwy #100 Annap. MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002

32. Registrar's Signature: [signature] D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42534

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathryn M. Fisher

2. Date of Death Month Day Year: December 27, 2001

3. Time of Death: 6:40 A M

4a. Facility Name (If not institution, give street and number): Loch Raven Genesis

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-10-1799

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 6, 1906

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 8720 Emge Road

10f. Zip Code: 21234

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Worker

16b. Kind of Business/Industry: Sandlers Department Store

17. Father's Name (First, Middle, Last): William Merritt

18. Mother's Name (First, Middle, Meiden Surname): Annie

19a. Informant's Neme/Reletionship (Type, Print): Ruth Wooden Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3 J. Beeson Court Baltimore, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 12/29/2001

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: Lynn B. Henss

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia — Due to (or as a consequence of): — Less than one day.

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Diabetes — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the pest 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant et time of deeth 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end manner as steted. 2☐ **Medicel Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Sunita Tripuraneni

29c. Licanse number: D30661

29d. Date signed (Month, Day, Year): January 4th 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SITEESH TRIPURANENI 5601 Loch Raven Blvd. Baltimore, Md - 21239

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002

32. Registrar's Signature: Bruce P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42535

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHARON HOWARD
2. Date of Death Month: December Day: 30 Year: 2001
3. Time of Death: 2 53 A M
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 219-74-6885
8. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCTOBER 26, 1961
9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 3700 GREENSPRING AVE.
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): JAMES HOWARD
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE HARRIS

19a. Informant's Name/Relationship (Type, Print): SHELIA MCFADDEN (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 305 YUKON Street Apt. A KENN, North Carolina 27542

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): KING MEMORIAL PARK
Date: 1-5-02
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: MD1015
22. Name and Address of Facility: VAUGHN C. Greene 4905 YORK ROAD BALTIMORE, MARYLAND 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Severe gastrointestinal bleed
Due to (or as e consequence of):
Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coagulopathy
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Richard Camacho
29c. License number: 89449
29d. Date signed (Month, Day, Year): December 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Camacho, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002
32. Registrar's Signature: ▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Sharon Howard

RR

RR 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42536

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emily Hube

2. Date of Death: Month Dec Day 27 Year 2001

3. Time of Death: 0450 M

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-01-7765

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-4-1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 309 Delma Avenue

10f. Zip Code: 21122

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Anton Kalivoda

18. Mother's Name (First, Middle, Maiden Surname): Mary Jericek

19a. Informant's Name/Relationship (Type, Print): Joyce Giguere - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 410 Goldsborough Street, Easton, MD 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem. Park

Date: 12/31/2001

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Paul Hogan

22. Name and Address of Facility: Singleton Funeral Home, P.A. 1 Second Avenue S.W. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Chronic obstructive Pulmonary disease

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tim Woods

29c. License number: D0057635

29d. Date signed (Month, Day, Year): 12 27 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy G. Woods 1655 Crofton Blvd. Suite 207 Crofton MD 21114

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002

32. Registrar's Signature: Brenda D Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42537

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Peelyo Kim

2. Date of Death: Month 12 Day 22 Year 01

3. Time of Death: 10:37am M

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 229-67-3622

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 15, 1924

9. Birthplace (State or Foreign Country): NORTH KOREA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8203 ATHENA LANE

10f. Zip Code: 21144

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES CLERK

16b. Kind of Business/Industry: SALES

17. Father's Name (First, Middle, Last): Kim Hak Kyu

18. Mother's Name (First, Middle, Maiden Surname): Yang Ci

19a. Informant's Name/Reletionship (Type, Print): SONG S. VAN ALLEN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8203 ATHENA LANE, SEVERN, MARYLAND 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE MEMORIAL GARDENS Date: 12/29/2001

20c. Location - City or Town, State: CHESAPEAKE, VA.

21. Signature of Funeral Service Licensee: ▶ Stephanie All-

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Ischemic bowel with perforation.

Approximate Interval Between Onset and Death: 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ P. Sean Van Sijl M.D.

29c. License number: AU417C435U13171

29d. Date signed (Month, Day, Year): 12/22/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): P. Sean Van Sijl M.D. 22 South Greene St. Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002

32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42538

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Doris L. Kemper	December 30, 2001	11:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shore Nursing & Rehabilitation Center	Denton	Caroline

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217 09 7128	1☐M 2☒F	81 Yrs.			May 13, 1920	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Talbot	Easton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
29353 Will Street	21601	U.S.

11. Maritat Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Burkman	Francia Brush

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Francis Kemper / Husband	311 Hammonds Lane Baltimore, Maryland 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Holy cross Cemetery	01/03/2002	baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Donna M Zramiewski	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimers Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
K Moffett	D51639	December 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen Moffett, M.D., 609 Daffin Lane, Denton, Maryland 21629

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2002	Jenna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

85
2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

2001 42539

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
LEROY LOCKLEY	12	31	01	1126 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Med Center	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
150-24-2320	1☒M 2☐F	68 Yrs.					April 9, 1933	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2201 Walbrook Ave.	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	Salesman	Automobile

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leroy Lockley	Pearl E. Taylor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Harriet Lockley (wife)	8755 Fontana Lane Balto. Md. 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Garrison Forest	1/10/2002	Owings Mills, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Joseph L. Russ	Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. MRSA Meningitis	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	26d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ R. Naglieri Resident Physician	P13138	12/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rosalie Naglieri MD 225. Greene St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2002	▶ Penny D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#20b per fh G803 010802SS

Certificate of Death

Reg. No. 2001 42540

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Armondo Lugo

2. Date of Death (Month, Day, Year): December 16, 2001

3. Time of Death: 1330

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 581-42-5357

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 15, 1930

9. Birthplace (State or Foreign Country): Puerto Rico

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2541 E. Biddle St.

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unk; College (1-4or 5+): Unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waterman

16b. Kind of Business/Industry: Private Company

17. Father's Name (First, Middle, Last): Jose Sanchez

18. Mother's Name (First, Middle, Maiden Surname): Gutelpa Sanchez

19a. Informant's Name/Relationship (Type, Print): Ms. Joeann Sanchez (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2210 E. Biddle St. Balto. Md. 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, another place): Mt. Carmel Voshell Mem. Gardens

Date: 12/27/01 ~~12/24/2001~~

20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Herbert P. Henderson Jr. MD

29c. License number: D0051924

29d. Date signed (Month, Day, Year): December 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Herbert P. Henderson Jr. MD 2975 Manchester Rd Unit A Manchester MD 21102

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42541

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROLAND LYLES
2. Date of Death Month: 12 Day: 31 Year: 01
3. Time of Death: 13:48
4a. Facility Name *(If not institution, give street and number)*: VAMC 10 N. GREENE ST
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-34-5269
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11-7-1937
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 341 WHITRIDGE AVE
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): -12- College (1-4or 5+): -0-
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ELECTRICIAN
16b. Kind of Business/Industry: AIRPORT

17. Father's Name *(First, Middle, Last)*: CHARLES LYLES
18. Mother's Name *(First, Middle, Maiden Surname)*: ELENORA LYLES

19a. Informant's Name/Relationship *(Type, Print)*: RALPH LYLES (BROTHER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 341 WHITRIDGE AVE. BALTIMORE, MARYLAND 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARRISON FOREST VETERANS
Date: 1-11-2002
20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Jaratha J. Hibner
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ESOPHAGEAL CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert F. Cord
29c. License number: D0054861
29d. Date signed *(Month, Day, Year)*: Dec. 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT CORDER 10 NORTH GREENE ST.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2002
32. Registrar's Signature: Deanna D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LYLES, ROLAND

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42542

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael J. LaffertY
2. Date of Death Month / Day / Year: Dec 31 2001
3. Time of Death: 0035
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: AA

Funeral Director

5. Social Security Number: 220-48-6779
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 23, 1950
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: PASADENA
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 8621 HOULTON HARBOUR
10f. Zip Code: 21122
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No — If Yes, Give Year or Dates: 1968-1970
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: RETAIL MANAGER
16b. Kind of Business/Industry: VIDEO GAME
17. Father's Name *(First, Middle, Last)*: ROBERT FRANCIS LAFFERTY
18. Mother's Name *(First, Middle, Maiden Surname)*: DOLORES KRAUS
19a. Informant's Name/Relationship *(Type, Print)*: MRS. BARBARA LAFFERTY (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8621 HOULTON HARBOUR, PASADENA, MD. 21122
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETERANS CEMETERY — Date: 1/4/2002
20c. Location - City or Town, State: CROWNSVILLE, MD.
21. Signature of Funeral Service Licensee: ▶ Michael N Vefida M01241
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Heart Disease	UNK.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residance 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William P. Jones, MD Deputy
29c. License number: D 06054
29d. Date signed *(Month, Day, Year)*: 12/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2002
32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #1 PER PHY G803 1/08/02 jh **Certificate of Death** Reg. No. 2001 42543

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~MANOR CARE RUXTON~~ MARGIE ETTA MORTON OAKES

2. Data of Death Month Day Yaar: DECEMBER 30, 2001

3. Time of Death: 9:50 AM M

4a. Facility Name (If not institution, giva street and number): Manor Care Ruxton

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Numbar: 341-44-5495

6. Sax: 1☐M 2☒F

7. Aga (In yrs. last birthday): 103 Yrs.

If Undar 1 Year: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): Nov. 30 1898

9. Birthplace (Stata or Foreign Country): Illinois

Usual Rasidanca of Decedant

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 7001 N. Charles St.

10f. Zip Code: 21204

10g. Citizan of What Country?: USA

11. Marital Status: 1☐Never Marriad 2☐Marriad 3☒Widowad 4☐Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratirad): Homemaker

16b. Kind of Businass/Industry: Own Home

17. Father's Name (First, Middla, Last): Albert L. Morton

18. Mothar's Nama (First, Middla, Maidan Surnama): Carrie Moore

19a. Informant's Name/Ralationship (Type, Print): Morton W. Oakes/Son

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code): 3600 Colonial Rd., Dover, PA 17315

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify)

20b. Placa of Disposition (Nama of cematary, crematory or othar placa): Memory Gardens

Date:

20c. Location - City or Town, Stata: Arlington Heights, IL

21. Signatura of Funaral Sarvica Licansaa: ▶ Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only ona causa on aach lina.

Immediate Cause (Final disease or condition rasulting in death): a. CARCINOMA OF NOSE — Approximate Intarval Batwaan Onsat and Daath: 2-3 YEARS

Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or injury that initiatad events rasulting in daath) Last:

b. Dua to (or as a consaquanca of):

c. Dua to (or as a consaquanca of):

d. Dua to (or as a consaquanca of):

IF FEMALE:

23b. Was decedent pregnant in tha past 12 months? 1☐Yas 2☒No 9☐Unknown

23c. If yas, outcoma of pragnancy 1☐Liva birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown

23d. Data of delivery Month Day Yaar

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23e. Did tobacco use contributa to the causa of daath? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performad? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to compiation of causa of daath? 1☐Yes 2☒No

25. Was case referrad to medical examiner? 1☐Yas 2☒No

28. Placa of Death (Check only one): Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA Othar: 4☒Nursing Homa 5☐Residence 6☐Othar (Specify)

27. Mannar of Daath: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding investigation 6☐Could not ba datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurrad

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒**Cartifying Phyaician:** To tha bast of my knowladga, daath occurrad at tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐**Madical Examinar:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the causa(s) and manner stated.

29b. Signatura and title of cartifiar: [signature]

29c. Licansa numbar: D34827

29d. Data signad (Month, Day, Yaar): 12/31/01

30. Name and addrass of parson who completad cause of death (Item 23a) (Type, Print): JAMES G EBELING,M.D. 7401 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Data filad (Month, Day, Yaar): JAN 0 8 2002

32. Registrar's Signatura: ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 42544

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: Charles Edward Reechel
2. Data of Death Month / Day / Year: DEC 12, 2001
3. Tima of Death: 12:15pm
4a Facility Name *(If not institution, give street and number)*: 1603 S. Clinton St.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-32-6457
6. Sex: 1 [X] M 2 [ ] F
7. Age *(in yrs. last birthday)* Yrs.: 65
If Under 1 Year: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 14, 1936
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. Stata: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1603 S. Clinton St.
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Black, Whita, etc. Specify: White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Physical Therapist
16b. Kind of Business/Industry: Johns Hopkins University

17. Father's Nama *(First, Middle, Last)*: Gusto Reechel
18. Mother's Name *(First, Middle, Maiden Surname)*: Bernadine Parks

19a. Informant's Name/Relationship *(Type, Print)*: Erma Reechel/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1603 S. Clinton St. Baltimore, MD 21224

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: Anatomic Gift Foundation
Date: 12/12/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee ▶ [signature]
22. Name and Address of Facility: ANATOMIC GIFT FOUNDATION 13948 LAUREL AVE. LAUREL MD 20707

Physician /Medical Examiner

23a. Part1. Entar the diseasa, or complications that caused tha daath. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only ona causa on each lina.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final disaase or condition resulting in death)
a. Metastatic rectal cancer — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: [✓] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [✓] 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ M Cuttell, Staff Physician
29c. License number: D19714
29d. Data signad *(Month, Day, Year)*: 12/26/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL CUTTELL JHBMC 4940 EASTON AVE, BALTIMORE, MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2002
32. Registrar's Signatura ▶ P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42545

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
George C. Rader	December 7, 2001	6:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3405 Benson Ave.	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-38-8978	1 X M 2 ☐ F	60 Yrs.			March 5, 1941	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3405 Benson Ave.	21227	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates: Airforce	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th		Construction	Housing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Rader	Doris Miller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Harthauson/Neice	3405 Benson Ave Baltimore MD 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify)	Anatomic Gift Foundation	12-7-01	Laurel, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure, endstage	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease	20 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as steted.
2 ☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Mark D. Hansen, MD	D48215	1/2/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Perry Point VA Medical Center, Perryville, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2002	▶ [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

SCHRODER

VOID

CERTIFICATE #

01-49546

SEE

CERTIFICATE #

02-00625

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42547

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILLIE A. SWANN
2. Date of Death: Month December Day 31 Year 2001
3. Time of Death: 1:30 AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 215-01-0306
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 96 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JANUARY 13, 1905
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2304 LYNDHURST AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: HEALTHCARE

17. Father's Name (First, Middle, Last): JAMES TOMONEY
18. Mother's Name (First, Middle, Maiden Surname): ELIZA JANE

19a. Informant's Name/Relationship (Type, Print): ALAN SHAPIRO (POWER OF ATTORNEY)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2300 LYNDHURST AVE • BALTIMORE, MD • 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): MD NAT'L MEMORIAL PK
Date: 1/3/02
20c. Location - City or Town, State: LAUREL, MD

21. Signature of Funeral Service Licensee: [signature] MD 015
22. Name and Address of Facility: YAUGHN Greene Funeral Svcs. 4905 YORK ROAD BALTIMORE, MD 21212

Patient known as Amelia Swann

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death): a. Myocardial Infarction
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b. Due to (or es a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnency 4 ☐ Pregnent et time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☒ Unknown

24e. Was en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: David L. Lee MD
29c. License number: RES 000
29d. Date signed (Month, Day, Year): December 31, 2001
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): David Lee Sinai Hospital of Baltimore.

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2002
32. Registrar's Signature: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

RR

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#23a-line c per phys C803 010802 ss

Certificate of Death

Reg. No. 2001 42548

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Sue Carol Shugh	December 21 2001	9:30 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel General Hospital	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212 30 9239	1☐M 2☒F	69 Yrs.					Oct. 19, 1932	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Pasadena	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8442 Spring Road	21122	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2 years	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Henthorn	Anna Fuller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
J. Albert Shugh / Husband	8442 Spring Road Pasadena, Maryland 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glen Haven Mem. Park	12/24/2001	Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna M Zramkowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. acute cardiac arrest	24 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. acute respiratory failure	24 hours
	Due to (or as a consequence of): c. ACUTE ANOXIC BRAIN INJURY	24 Hours
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Robert T Peterson MD	D24804	12-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert T Peterson MD AAMC Annapolis md 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2002	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42569

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
CHARLES	E.	SMITH	DECEMBER 30, 2001	9:15A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
QUAIL RUN ASSISTED LIVING	CROFTON	ANNE ARUNDEL

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
232-01-6415	1☒M 2☐F	86 Yrs.			DEC. 30, 1915	WV

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	ANNAPOLIS	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whel Country?
2537 PAINTER COURT	21401	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedenl of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americen Indien, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		FOREMAN	STEEL

17. Fether's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surneme)		
CHARLES	GUY	SMITH	LILLIAN	BELL	EDWARDS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
STEPHANIE LINTON (DAUGHTER)	501 ASH TRAIL, CROWNSVILLE, MARYLAND 21032

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Buriel 2☐Cremetion 3☐Removel from State 4☐Donation 5☐Other (Specify)	CHESAPEAKE CREMATION CENTER, LLC	1/4/2002	STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee: Michael N Vehula M01241

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in deeth) a.	Alzheimer's disease	many yrs.
Due to (or as a consequence of): b.	Parkinson's disease	many yrs
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last — Due to (or as e consequence of): c.	Non Insulin dependent Diabetes Mellitus	many yrs.
Due to (or as e consequence of): d.		

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was an autopsy performed?	24b. Were eulopsy findings available prior to completion of ceuse of deeth?
1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Menner of Death	28a. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred el the lime, date and place, and due lo the cause(s) and manner es steted. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M. Nusairee	D40519	12-31-01

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): MIRZA M. NUSAIREE 7845 OAKWOOD ROAD, SUITE 200, GLEN BURNIE, MD. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 8 2002	Bernard D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42550

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herman Waddell

2. Date of Death: Month 12 Day 19 Year 01

3. Time of Death: 8:30 pm

4a Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 214-78-1535

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)*: 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9 29 60

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 814 W. North Avenue

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.

11. Marital Status: X 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX 1 Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) XX 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 grade; College (1-4or 5+): unknown

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Roofer

16b. Kind of Business/Industry: Roofing Business

17. Father's Name *(First, Middle, Last)*: Francis Waddell

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Frances Ross

19a. Informent's Name/Reletionship *(Type, Print)*: Bernice Ross-Grandmother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 814 W. North Avenue-Balto, Md

20a. Method of Disposition: XX 1 Burial 2 Cremetion 3 Removel from Stete 4 Donstion 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion Cemetery

Date: 12/26/01

20c. Location - City or Town, Stete: Balto, Md

21. Signeture of Funeral Service Licensee: Irvin Carroll

22. Name end Address of Feciiity: Irvin Carroll Funeral Home 1712 W. North Ave/Balto, Md 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)

a. Pneumothorax

Due to (or as a consequence of):

b. Respiratory Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Pneumocystis Carinii Pneumonia

Due to (or as a consequence of):

d. End Stage Acquired Immunodeficiency Syndrome

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown

24a. Was an autopsy performed? 1 Yes 2 ✓ No

24b. Were autopsy findings eveilabie prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical exeminer? 1 Yes 2 ✓ No

26. Piece of Death *(Check only one)*: Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Menner of Death: 1 ✓ Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ✓ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted.

29b. Signeture snd titie of certifier: Richard Camacho

29c. License number: 89449

29d. Date signed *(Month, Day, Year)*: 12/19/01

30. Name snd address of person who completed cause of death (Item 23a) (Type, Print): Richard Camacho, M.D. 90 Maryland General Hospital

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 0 8 2002

32. Registrar's Signeture: Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar

Certificate of Death

Reg. No. 2001 42551

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Virginia Crivelli	December	14	2001	11:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Howard County General Hospital	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-22-3840	1☐M 2☒F	73 Yrs.					07/20/1928	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Ellicott City	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3344 Governor Howard Drive	21043	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12		Customer Service	Telemarketing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Bender	Katherine Bauer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Karen Jay Bell/ Daughter	3344 Governor Howard DR Ellicott City, MD 21043

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Crestlawn Mem. Garden	12/19/2001	Marriottsville, MD

21. Signature of Funeral Service Licensee ▶ John E Steffey (Mooney)

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, 736 Edmondson Ave Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	3 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CEREBROVASCULAR DISEASE	1 YEAR
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELITUS

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Scott Maurer MD	D29909	JANUARY 8, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SCOTT MAURER MD 2465 ROUTE 97 GLENWOOD MD 21738

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 09 2002	▶ B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42552

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Dakos

2. Date of Death Month / Day / Year: December 29, 2001

3. Time of Death: 10:30 PM

4a. Facility Name *(If not institution, give street and number)*: 8020 Lansdale Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-28-9895

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2/14/1931

9. Birthplace *(State or Foreign Country)*: Greece

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8020 Lansdale Road

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator

16b. Kind of Business/Industry: Steel

17. Father's Name *(First, Middle, Last)*: Pantelis Yianoudakos

18. Mother's Name *(First, Middle, Maiden Surname)*: Georgia Vasilakos

19a. Informant's Name/Relationship *(Type, Print)*: Kyriaki Dakos

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8020 Lansdale Road Baltimore, Maryland 21224

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crametory or other piece)*: Gardens of Faith

Date: 1/3/02

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Richard L Bradley

22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home Inc. 2134 Willow Spring Road Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cancer of Lung c Mets to Brain	1 year
Due to (or as a consequence of): b.	Copd A due to Cancer + Mets	2-3 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Systemic Hypertension + VCD Dm	5+ yrs
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: P 04241

29d. Date signed *(Month, Day, Year)*: 1.2.02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. A. Rowing 224 B. Blvd Balto md 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 9 2002

32. Registrar's Signature:

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

KEVIN M. GREEN
)!
01-7260-510
Unknown (01-356)
TLC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 42553
Reg. No.

UNPENDED 060402: ITEMS#23a,27,28a-f per ME G808 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KEVIN M. GREEN
2. Data of Death (Month, Day, Yaar): December 22, 2001
3. Time of Death: 09:06 a.m.
4e. Facility Name (If not institution, giva street and number): 3000 Block South Hanover Street
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 216-86-9226
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 35 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 6/9/66
9. Birthplace (State or Foraign Country): MD

Usuel Rasidance of Decedant

10a. State: MD
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yas 2 ☐ No
10e. Street and Number: 911 LEADENHALL ST Apt#606
10f. Zip Coda: 21230
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: ☒ 1 Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondery (0-12): 12 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): ukn
16b. Kind of Business/Industry: ukn

17. Fathar's Nema (First, Middle, Last): ELMER GREEN
18. Mothar's Nama (First, Middle, Maiden Surnama): MAGGIE HAWKINS

19a. Informant's Name/Ralationship (Type, Print): TONYA HAWKINS
19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Coda): 7102 ROLLING BEND ROAD WOODLAWN MD. 21244

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Steta 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or othar place): ARBUTUS MEM PARK
Date: 1/10/02
20c. Location - City or Town, Stete: Arbutus Md.

21. Signatura of Funeral Service Licensee: Paul G Step
22. Nama and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused tha deeth. Do not enter the moda of dying, such as cardiac or raspiratory errest, shock, or haart failura. List only one cause on aach line. — Approximeta Interval Between Onset and Death

Immediate Causa (Finel disaasa or condition resulting in deeth)
a. DROWNING
Dua to (or as a consequence of):
Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Diseese or injury that initieted evants resulting in death) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No

25. Was cesa rafarred to medical examiner? 1 ☒ Yas 2 ☐ No
26. Plece of Death (Check only ona): Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA | Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☒ Othar (Specify) Scene

27. Manner of Deeth: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending investigation 6 ☒ Could not be determined
28a. Data of Injury (Month, Day Year): Found: 12-22-01
28b. Time of Injury: Found at: 8:34a M
28c. Injury at Work? 1 ☐ Yas 2 ☒ No
28d. Describe how injury occurred: Unknown
28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify): water
28f. Location (Streat and Number or Rural Route Number, City or Town, State): 2600 Insulator Dr., Baltimore, MD

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To tha best of my knowledge, deeth occurred at tha time, date and plece, and due to the cause(s) and mannar es stated. 2 ☒ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and placa, and due to the causa(s) and mannar steted.
29b. Signature and title of certifier:
29c. Licansa number: O.C.M.E.
29d. Data signed (Month, Day, Year): December 23, 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): [illegible] A. KOHLI 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2002
32. Registrer's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42554

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERTRUDE GREIFZU

2. Date of Death: Month 12 Day 28 Year 2001

3. Time of Death: 7:25 A M

4a. Facility Name (If not institution, give street and number): Rolling Meadows Assisted Living

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Catonsville

Funeral Director

5. Social Security Number: 212-09-3000

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 11, 1916

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5607 ASHBOURNE ROAD

10f. Zip Code: 21227

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ALFRED MORRIS

18. Mother's Name (First, Middle, Maiden Surname): CATHERINE KRASTEL

19a. Informant's Name/Relationship (Type, Print): BARBARA KERR/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5910 RUSTIC LANE BALTIMORE, MD. 21227

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: ▶ ROBERT S. WADE ,DIRECTOR PER DVR.

22. Name and Address of Facility: STATE ANATOMY BOARD 655 W. BALTIMORE STREET BALTIMORE,MD. 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CARCINOMA — 12 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIFFUSE LARGE CELL LYMPHOMA OF THE STOMACH

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Damian E Burches MD

29c. License number: D42114

29d. Date signed (Month, Day, Year): 1/4/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAMIAN E. BURCHES MD 5411 OLD FREDERICK RD, SUITE C8, BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2002

32. Registrar's Signature: ▶ Bernice D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Greifzu, Gertrude

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42555

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KAI KERNTAE GENTRY
2. Date of Death Month: DECEMBER Day: 24, Year: 2001
3. Time of Death: 1804 M

4a. Facility Name (If not institution, give street and number): MERCY MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: N/A
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.: 15
8. Date of Birth (Month, Day, Year): 12/24/2001
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: N/A
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: N/A
10f. Zip Code: N/A
10g. Citizen of What Country? N/A

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): (Unknown)
18. Mother's Name (First, Middle, Maiden Surname): Kia Gentry

19a. Informant's Name/Relationship (Type, Print): Kia Gentry/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1528 N. Wolfe ST Baltimore, MD 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 12/28/2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edison K. Perkins
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)
a. EXTREME PREMATURITY
Due to (or as a consequence of):
b. MATERNAL PRETERM DELIVERY
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
Due to (or as e consequence ot):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kathryn Dalton MD
29c. License number: T137830
29d. Date signed (Month, Day, Year): DECEMBER, 26 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. TABIBI, MD c/o Mercy Medical Center, 301 St. Paul Place, Balt. MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2002
32. Registrar's Signature: [illegible]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42556

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aline Ursula Hoody
2. Date of Death (Month, Day, Year): December 29, 2001
3. Time of Death: 18:15P M
4a. Facility Name (If not institution, give street and number): 2409 Fairway
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-14-3149
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/2/1919
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2409 Fairway
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 2 — Collega (1-4or 5+):
16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harry Longwell
18. Mother's Nama (First, Middle, Maiden Surnama): Mattie Murphy

19a. Informant's Name/Relationship (Type, Print): Sandy Hoody
19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code): 2409 Fairway Dundalk, Maryland 21222

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cametery, crematory or other place): Carroll Crematory
Date: 1/2/01
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: ▶ Elizabeth Selenski
22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home Inc. 2134 Willow Spring Rd. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intervat Between Onset and Death

Immadiate Cause (Final disease or condition resulting in death): a. Cardiac Arrest — MINUTES

Sequentially list conditions, if any, laading to immediate causa. Enter Undarlying Causa (Disaase or injury that initiated avents rasulting in daath) Last:
b. Dua to (or as a consequence of): Atherosclerosis — Years
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedant pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Liva birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Alzheimer's Type

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☒ No

25. Was casa refarred to madical examinar? 1☐ Yas 2☒ No
26. Place of Death (Chack only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datermined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Ptace of Injury - At homa, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) and mannar as stated. 2☐ Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifiar: ▶ David H Madoff, MD, PhD
29c. Licanse number: D31419
29d. Date signed (Month, Day, Year): 1/2/02
30. Name and addrass of person who complatad cause of daath (Item 23a) (Typa, Print): 5601 Loch Raven Blvd, Baltimore MD 21239-2995

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2002
32. Registrar's Signature: ▶ Bonnie D Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-7390-510
B.K.S
UNKNOWN 01-365
MARY ANN WILSON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42557

UNPENDED/ AMENDED ITEMS #1,23a,ptII,27 per ME C805 ss 012802

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary A. Wilson ~~MARY ANN KIRBY-WILSON~~
2. Date of Death: Month DEC. Day 31, Year 2001
3. Time of Death: 12:33 PM
4a. Facility Name (If not institution, give street and number): 1902 EDMONDSON AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-62-7212
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 48 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 19, 1953
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1828 EDMONDSON AVENUE
10f. Zip Code: 21215
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CERTIFIED MEDICINE AIDE
16b. Kind of Business/Industry: HOSPITAL

17. Fether's Neme (First, Middle, Last): PETE SMITH
18. Mother's Name (First, Middle, Maiden Surneme): ELQIA LEE INGRAM

19e. Informent's Name/Relationship (Type, Print): LINDA ARMSTRONG (SISTER)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1 N. HILTON STREET BALTIMORE, MD 21229

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): MT. ZION CEMETERY
Dete: 1/9/02
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Feciility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. HYPERTROPHIC CARDIOMYOPATHY
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last: b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: FIBROFATTY LIVER

23b. Did tobacco uss contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☒ Yes 2☐ No
26. Piece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) end menner es stated. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ J. M. Ke for
29c. License number: O.C.M.E
29d. Dete signed (Month, Dey, Year): JAN. 1, 2002

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): M. Kovell, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): JAN 0 9 2002
32. Registrer's Signeture: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM #23b PER PHY G803 1/09/02 TH

Reg. No. 2001 42558

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Estelle B. Knell	December 23, 2001	3:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-12-7242	1☐M 2☒F	77 Yrs.			Sept. 29, 1924	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8105 Gray Haven Road	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6 Years		Sales Clerk	Cooks Department Store Retail Sales

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Rosenfeld	Lillian Horowitz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Gail E. Nadolny (Daughter)	933 Foxwood Lane Essex, Maryland 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Holly Hill Mem. Gdns.	12/27/2001	Middle River, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephanie Massey	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gastrointestinal Hemorrhage	10 days
Due to (or as a consequence of):	b. ~~Perforated Ulcer~~ PEPTIC ULCER DISEASE	2 WEEKS ~~10 days~~
Due to (or as a consequence of):	c. ~~Peptic ulcer disease~~	~~2 weeks~~
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal failure Chronic Obstructive pulmonary disease Cerebrovascular accident diabetes mellitus

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Cyril Rivende	D56601	December 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Cyril Rivende 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 9 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Estelle Knell

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#23 fixed

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42559

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence Mahew

2. Date of Death: Month 11 Day 17 Year 01

3. Time of Death: 950 pm

4a. Facility Name (If not institution, give street and number): Home 1140 Marlboro Rd Rte 408

4b. City, Town, or Location of Death: Lothian, MD

4c. County of Death: Ann Arundel

Funeral Director

5. Social Security Number: 214-60-3165

6. Sex: 1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-8-50

9. Birthplace (State or Foreign Country): Washington D.C

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Lothian

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1140 Marlboro Road

10f. Zip Code: 20711

10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Helper

16b. Kind of Business/Industry: Saw Mill

17. Father's Name (First, Middle, Last): Clarence Ellsworth Mayhew

18. Mother's Name (First, Middle, Maiden Surname): Catherine Bodmer

19a. Informant's Name/Relationship (Type, Print): Virginia Moreland/Caretaker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1140 Marlboro Road Lothian, MD 20711

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: PER DVR Ronald s Wade Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Head and Neck Carcinoma — 2yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cachexia

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patience Daniels MD

29c. License number: D0054444

29d. Date signed (Month, Day, Year): 1/2/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patience Daniels MD 3710 Riviera St Stella Temple Hills, MD 20748

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2002

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #23a&B PER PHY G1/09/02 JH

Certificate of Death

Reg. No. 2001 42560

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOTTIE MOHR

2. Data of Death: Month 12 Day 28 Yaar 2001

3. Tima of Death: 5:00 PM

4a. Facility Nama (If not institution, give street and number): St. Joseph Nursing Home

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Sociel Security Number: 219-12-9200

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 101 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): FEB 21, 1900

9. Birthplace (Stete or Foreign Country): Maryland

Usuel Residence of Decedant

10a. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1222 Tugwell Drive

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Merital Status: 1☐ Navar Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indien, Black, Whita, atc. Specify: White

15. Decedant'a Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Fathar's Nama (First, Middle, Last): George W. Knopp

18. Mother's Nama (First, Middle, Maiden Surname): Grace S. Boyd

19a. Informant's Name/Relationship (Type, Print): Shirley K. Flinn/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3606 MacAlpine Road Ellicott City, MD 21042

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Steta 4☐ Donation 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): William Watters Memorial Cemetery

Data: 1-2-02

20c. Location - City or Town, Stata: Cooptown, MD

21. Signeture of Funeral Service Licensee: Edward A. Gregorchik

Edward A. Gregorchik

22. Nama and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the daeth. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on aach lina.

Approximata Interval Batween Onsat and Death

Immediate Cause (Final disaasa or condition resulting in death): a. Chronic Renal Failure — 1-2 Years

Dua to (or as a consequanca of): ARTERIOSCLEROSIS — 5 YEARS

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury thet initieted events resulting in death) Last:

b. Dua to (or as a consequanca of): CONGESTIVE HEART FAILURE — 1½ YEARS

c. Due to (or aa a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Plece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Rasidenca 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Dey Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated. ☐ **Medical Examiner**: On the besis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha cause(s) and menner atetad.

29b. Signature and titla of certifier: Patrick White M.D.

29c. License number: D23365

29d. Data signed (Month, Dey, Year): 12/28/01

30. Nama and address of person who completed cause of daath (Item 23a) (Type/Print): Patrick White, 405 Frederick Rd, #202, Baltimore, MD 21228

State Registrar

31. Data filed (Month, Day, Year): JAN 0 9 2002

32. Registrar's Signatura: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#23a per phys G803 010902 ss

Certificate of Death

Reg. No. 2001 42561

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Raymond Thomas Paszkiewicz

2. Date of Death Month Day Year: December 27, 2001

3. Time of Death: 9:53 PM

4a. Facility Name (If not institution, give street and number): 5245 King Avenue

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

5. Social Security Number: 220-20-0648

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 26, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 5245 King Avenue

10f. Zip Code: 21237

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vending Attendant

16b. Kind of Business/Industry: Vending

17. Father's Name (First, Middle, Last): Thomas Paszkiewicz

18. Mother's Name (First, Middle, Maiden Surname): Frances Barzyk

19a. Informant's Name/Relationship (Type, Print): Wife Mrs. Josephine Paszkiewicz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5245 King Ave. Rosedale, Maryland 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus Cemetery

Date: 12/31/2001

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Stephanie Nassef

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ~~PNEUMONITIS~~ PNEUMONIA — 7 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. ~~Cerebrovascular disease~~ — 6 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Carcinoma of the tongue

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David I Zolet MD

29c. License number: D 33634

29d. Date signed (Month, Day, Year): 12/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID I. ZOLET, MD 9105 FRANKLIN SQUARE DR, #309, BALT, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2002

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42562

AMEND ITEM #23a PER PHY G803 1/09/02 JH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
SADIE	SOBELMAN	December 28, 2001	1824

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-24-3522	1 ☐ M 2 ☒ F	96 Yrs.			5/4/1905	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6317 PARK HEIGHTS AVE #211	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOSEPH BLOCK	MARGARET SHAPIRO

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. SYLVAN ISAAC/FRIEND	9505 REISTERSTOWN ROAD #3 SOUTH OWINGS MILLS MD21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	OHEB SHALOM	12/30/01	REISTERSTOWN, MD.

21. Signature of Funeral Service Licensee: Michael Bryan

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Aspiration PNEUMONIA	40 minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia, congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
R McClure DO	RES 000	December 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. McClure DO, Sinai Hospital, 2401 West Belvedere Avenue, Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 9 2002	Donna D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Kraun as Sobelman, Sadie

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42563

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
George Shortt	December 31 2001	2:00P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital Center	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
046-09-3051	1 [X] M 2 [ ] F	96 Yrs.			11 -15- 1905	Mass.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Dundalk	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8176 Midhaven Rd.	21222	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Sheet Metal Worker	Metal

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George E. Shortt	Matilda Strong

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jennifer L. Price/Daughter	2018 Longview Ave., Balto.,Md. 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	OakLawn Cemetery	1-3-2002	Balto.,Md. 21224

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] 100531	Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd.,Balto., Md. 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Myocardial Infarction	2 Days
Due to (or as a consequence of):	b. Congestive heart Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	c. Aortic Stenosis Moderate	
Due to (or as a consequence of):	d. Renal Failure	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	P 54736	December 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Kamlun Au Yeung 9000 Franklin Square Drive Baltimore MD, 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 9 2002	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Shortt, George

DHMH 17 Rev 1/2001

ORIGINAL

01-7238-510
B.K.S
UNKNOWN 01-353
GIORGIO WASHINGTON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #3&10d PER FH &dvr g803 1/09/02 JH

Certificate of Death

Reg. No. 2001 42564

Physician /Medical Examiner

Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Giorgio Washington

2. Date of Death — Month: DEC. Day: 21 Year: 2001

3. Time of Death: 0423AM ~~0423 AM~~

4a. Facility Name *(If not institution, give street and number)*: 4600 KERNWOOD AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

5. Social Security Number: 219-02-9192

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 26 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 8, 1975

9. Birthplace *(State or Foreign Country)*: West Germany

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐Yes ~~2☐No~~ XX

10e. Street and Number: 11035 Misty Lynn Circle Apt. I

10f. Zip Code: 21030

10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed

16b. Kind of Business/Industry: Janitorial

17. Father's Name *(First, Middle, Last)*: Clifford A. Washington

18. Mother's Name *(First, Middle, Maiden Surname)*: Maria Bastone

19a. Informant's Name/Relationship *(Type, Print)*: Clifford A. Washington/Father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1035 Misty Lynn Circle Apt I, Cockeysville, MD

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Carmel Cemetery — Date: Jan 5 2002

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Gunshot Wounds
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? ~~1☒Yes~~ 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* AT SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*: UNK

28b. Time of Injury: UNK M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: STREET

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 4600 Kernwood Ave.

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: DEC. 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 9 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42565

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel Virginia Ardinger

2. Date of Death (Month, Day, Year): DECEMBER 31,2001

3. Time of Death: 2:00 AM

4a. Facility Name (If not institution, give street and number): RAVENWOOD LUTHERAN VILLAGE

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 213-16-1692

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan.27,1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 16618 Virginia Ave.

10f. Zip Code: 21795

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Joseph McKinley Hoffman

18. Mother's Name (First, Middle, Maiden Surname): Anna Catherine Poffenberger

19a. Informant's Name/Reletionship (Type, Print): Robert K. Ardinger | Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16618 Virginia Ave. Williamsport,MD 21795

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Lawn Mem. Park | Date: Jan.4,2002

20c. Location - City or Town, State: Hagerstown,Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Osborne Funeral Home 425 S. Conococheague St. Williamsport,MD 21795

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximeta Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE — 3 days

Due to (or as a consequence of):

b. End stage Renal Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d. Hypertension.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE, CARDIOMYOPATHY ATHEROSCLEROSIS; OSTEOARTHRITIS; HYPOTHYROID. DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D0022313

29d. Date signed (Month, Day, Year): 12-31-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eli Roza 12931 Oak Hill Ave. Hagerstown,MD 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 02 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ARDINGER, ETHEL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42566

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Connie Lee Angle
2. Date of Death (Month, Day, Year): December 28, 2001
3. Time of Death: 10:15pm
4a. Facility Name (If not institution, give street and number): 5524 WESTCOTT CIRCLE
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 218-50-4144
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 2, 1947
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5524 WESTCOTT CIRCLE
10f. Zip Code: 21703
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: MORTGAGE COMPANY

17. Father's Name (First, Middle, Last): CLARK W. HARWOOD
18. Mother's Name (First, Middle, Maiden Surname): NAOMI K. HINES

19a. Informant's Name/Relationship (Type, Print): GEORGE W. HINES, BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10445 BAILEY ROAD, HAGERSTOWN, MARYLAND 21742

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SMITHSBURG CREMATORY
Date: DEC. 29, 2001
20c. Location - City or Town, State: SMITHSBURG, MARYLAND

21. Signature of Funeral Service Licensee: Kelly Zimmerman
22. Name and Address of Facility: BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardiovascular Disease	15 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0035152
29d. Date signed (Month, Day, Year): 12.29.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. L. KRANTZ M.D. 180 Thos Johnson Dr Frederick, MD 21702

State Registrar

31. Data filed (Month, Day, Year): DEC 31 2001
32. Registrar's Signature: Jennifer G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42567

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Florence Alexander
2. Dete of Death — Month: December; Day: 21; Year: 2001
3. Time of Death: 2:45AM
4a. Facility Neme *(If not institution, give street end number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Sociel Security Number: 112-22-7521
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 77 Yrs. — If Under 1 Yeer: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: July 29, 1924
9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Ijamsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10265 Champions Court
10f. Zip Code: 21754
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: homemaker
16b. Kind of Business/Industry: own home

17. Fether's Name *(First, Middle, Last)*: Robert Heffer
18. Mother's Name *(First, Middle, Maiden Surname)*: Evelyn Heffernan

19a. Informent's Neme/Relationship *(Type, Print)*: Catherine Alspaugh/ daughter
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10265 Champions Ct. Ijamsville, MD 21754

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fairfax Memorial Park
Date: 12/24/01
20c. Location - City or Town, State: Fairfax, VA

21. Signature of Funeral Service Licensee: ▶ Catharine O. Hartzler
22. Name end Address of Facility: Hartzler Funeral Home, 11802 LibertyRd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. — Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)
a. INTRACRANIAL HEMORRHAGE
Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D44213 (MD)
29d. Date signed *(Month, Day, Year)*: 12/21/01

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): RAVI YARAMANCHILI MD 141 J.J. Dr #200 Frederick MD 21702

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 26 2001
32. Registrer's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12/26/01 amended 19a per FD/crw

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42568

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Allen

2. Date of Death: Month Dec, Day 20, Year 2001

3. Time of Death: 10:10 p.m.

4a. Facility Name (If not institution, give street and number): Carroll Lutheran Village

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-20-9048

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Oct 15, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 300 St. Luke Circle

10f. Zip Code: 21158

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager Paint Department

16b. Kind of Business/Industry: Hutzlers Dept. Store

17. Father's Name (First, Middle, Last): William Z. Gray

18. Mother's Name (First, Middle, Maiden Surname): Mary E. Donohue

19a. Informant's Name/Relationship (Type, Print): Elizabeth Endlich ~~(sister)~~ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3800 Robin Hood Way Sykesville, MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 12/27/2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis 2° to Urny Tract Infection — 1wk

Due to (or as a consequence of):
b. Advanced Dementia — 1yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D37949

29d. Date signed (Month, Day, Year): Dec. 21st, 2001

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Alexander Bozelka 295 Seven Ave, Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6
crw

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42569

EDWIN ABRAMS 577-40-7590

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
EDWIN	FRED	ABRAMS	DECEMBER 19 2001	0209 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-40-7590	1☒M 2☐F	73 Yrs.					September 27, 1928	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Worcester	Berlin	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3 Commodore Court	21811	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Chemical Engineer	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Meyer Abrams	Anna Grace Taylor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jeannette Abrams/Wife	3 Commodore Court, Berlin, MD 21811

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Beth Israel Cemetery	12/20/01	Salisbury, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. Ischemic Colitis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D34768	DECEMBER 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JEFFREY WIELAND, M.D. 400 E. SHORE DR. SALISBURY, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 2001	▶ [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42570

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Anita Bragunier
2. Date of Death Month Day Year: December 31, 2001
3. Time of Death: 8:00 PM
4a. Facility Name *(If not institution, give street and number)*: 13939 Weaver Avenue
4b. City, Town, or Location of Death: Maugansville
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-18-2077
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 18, 1924
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Maugansville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13939 Weaver Avenue
10f. Zip Code: 21767
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): N/A; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Fairchild Industry

17. Father's Name *(First, Middle, Last)*: Clyde Bragunier
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Barber

19a. Informant's Name/Relationship *(Type, Print)*: Hazel Holland / Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7302 Sharpsburg Pike, Sharpsburg, Md. 21782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery
Date: January 3, 2002
20c. Location - City or Town, State: Hagerstown, Md.

21. Signature of Funeral Service Licensee: Eric L. Brown Eric L. Brown
22. Name and Address of Facility: Rest Haven Funeral Home 1601 Pennsylvania Ave. Hagerstown, Md. 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CORONARY ARTERY DISEASE	YEARS
Due to (or as a consequence of): b.	DIABETES MELLITUS	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	ASTHMATIC BRONCHITIS	YEARS
Due to (or as a consequence of): d.	CONGESTIVE HEART FAILURE	YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher Wolfley
29c. License number: D0022043
29d. Date signed *(Month, Day, Year)*: 1/2/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 11110 MEDICAL CAMPUS RD HAGERSTOWN, MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42571

Bitner, Stephen, Melvin

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): STEPHEN MELVIN BITNER		2. Date of Death: Month Dec. Day 29 Year 01	3. Time of Death: 2035
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL	4b. City, Town, or Location of Death: HAGERSTOWN	4c. County of Death: WASHINGTON	
5. Social Security Number: 216-22-9461	6. Sex: 1 XX M 2 ☐ F	7. Age (In yrs. last birthday): 74 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 12, 1927	9. Birthplace (State or Foreign Country): MARYLAND		

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WASHINGTON	FAIRPLAY	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
17926 LAPPANS ROAD	21733	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12): 9	College (1-4or 5+)	BARBER	OWNED BARBER SHOP

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LLOYD BENJAMIN BITNER	MARY REBECCA STOCKSLAGER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARILYN M. NUNAMAKER, DAUGHTER	4914 HARPERS FERRY ROAD, SHARPSBURG, MD 21782

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ST. MARK'S CEMETERY	JAN. 2, 2002	BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kelly A. Zimmerman	BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Acute Renal Failure	one week
Due to (or as a consequence of):	b. Serratia marescens bacteremia	one week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	c. Infected Subclavian vein cathater tip	one week
Due to (or es e consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Advanced Pulmonary fibrosis
Severe Chronic obstructive Pulmonary disease

23b. Did tobacco uas contribute to the causs of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert Brull MD Personal Physician	D04359	Dec 30, 2001

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): Robert Brull 1459 Potomac Avenue Hagerstown, Md 21742

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 2 2002	▶ Brenda G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Bowers

VOID

CERTIFICATE #

01-42572

SEE

CERTIFICATE #

02-00539

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42573

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tammy Christine Byrd
2. Date of Death (Month, Day, Year): December 21 2001
3. Time of Death: 0701 AM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 213-72-8619
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 37 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 6, 1964
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Pennsylvania
10b. County: Franklin
10c. City, Town or Location: Waynesboro
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15282 Ridge Road
10f. Zip Code: 17268
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): laborer
16b. Kind of Business/Industry: electronics distributor

17. Father's Name (First, Middle, Last): Sylvester Franklin Hose, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Sheila Kay Shuman

19a. Informant's Name/Relationship (Type, Print): Jacqueline Grove - aunt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10818 Rosewood Dr., Hagerstown, Maryland 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory
Date: 12/22/01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple trauma — Due to (or as a consequence of): — Moments

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): Dec 21, 01
28b. Time of Injury: 0600 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Motor Vehicle Accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Ramp I 3- SL + State Line Rd
28f. Location (Street and Number or Rural Route Number, City or Town, State): At Entrance Ramp

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward W. Ditto III MD
29c. License number: DO-1062
29d. Date signed (Month, Day, Year): Dec 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward W. Ditto III MD 19,041 orchard Rd. Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EW

01-7346-043
mnmr
Patricia L. Boyd

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#28d per ME G805 031202 ss

Certificate of Death

Reg. No. 2001 42574

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Louise Boyd
2. Date of Death (Month, Day, Year): December 28, 2001
3. Time of Death: 1800
4a. Facility Name (If not institution, give street and number): Route 40 @ Ashton Road
4b. City, Town, or Location of Death: Clear Spring
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-36-4553
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 4, 1939
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Clear Spring,
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 169 Cumberland Street
10f. Zip Code: 21722
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 3 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): nurse/ program supervisor
16b. Kind of Business/Industry: Health Dept.
17. Father's Name (First, Middle, Last): Frank Mish Boyd
18. Mother's Name (First, Middle, Maiden Surname): Louise Seibert
19a. Informant's Name/Reletionship (Type, Print): Nancy Grove Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12455 Cedar Ridge Rd.Williamsport,MD 21795
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul Cemetery
Date: Dec.31,2001
20c. Location - City or Town, State: Clear Spring, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Donald Edwin Thompson Funeral Home, Inc 13607 National Pike Clear Spring,MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene
27. Manner of Death: 1☐Natural 2☑Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day, Year): 12-28-01
28b. Time of Injury: 1700 ☒P.M.
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred: WITH A VEHICLE Driver of ~~PASSENGER~~ CAR, COLLISION
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): ROADWAY
28f. Location (Street and Number or Rural Route Number, City or Town, State): RT40 CASHTOWN RD WASHINGTON MD
29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Marjorie McShane
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 29, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE A. KOREN MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001
32. Registrar's Signature: [signature] Sparks

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42575

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cletus Eugene Barnes, Sr.

2. Date of Death: Month December Day 21 Year 2001

3. Time of Death: 11 pm

4a. Facility Name *(If not institution, give street and number)*: 11317 Liberty Rd.

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-36-9471

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Sept. 14, 1914

9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. Stata: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yas 2 ☒ No

10e. Street and Number: 11317 Liberty Rd.

10f. Zip Coda: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada compliated)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Farmer

16b. Kind of Businass/Industry: Dairy

17. Fathar's Nama *(First, Middla, Last)*: Harry T. Barnes

18. Mothar's Name *(First, Middle, Maiden Surnama)*: Rilla Poole

19a. Informant's Name/Ralationship *(Type, Print)*: Geneva Delphey/ daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 11919 Green Valley Rd. Union Bridge, MD 21791

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Glade Cemetery

Data: 12/24/01

20c. Location - City or Town, Stata: Walkersville, MD

21. Signature of Funaral Sarvica Licensee: Catharine O. Hartzler

22. Nama and Addrass of Facility: Hartzler Funeral Home, 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona cause on aach line.

Approximata Intarval Batween Onset and Death

Immediata Cause (Finai disaase or condition rasulting in death): a. Acute MI — 1 D.

Dua to (or as a consequence of): CAD — 15 yrs

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated avants rasulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Wes casa rafarrad to medical examinar? 1 ☐ Yas 2 ☒ No

26. Place of Death *(Check only ona)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Othar: 4 ☐ Nursing Homa 5 ☒ Rasidanca 6 ☐ Othar *(Specify)*

27. Mannar of Daath: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describa how injury occurrad

28a. Placa of injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledga, daath occurrad at the tima, data and placa, and dua to the causa(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurrad at the tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier: [signature]

29c. Licansa number: D20330

29d. Data signad *(Month, Day Year)*: 12/24/01

30. Name and address of parson who complatad cause of death (Item 23a) (Type, Print): John Albright 10 W. Main St, Union Bridge, MD 21791

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 26 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

25
CTS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42576

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herman Blaney
2. Date of Death: Month 12 Day 25 Year 2001
3. Time of Death: 3:10 P M
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-09-9126
8. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 28 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3906 Hayward Ave.
10f. Zip Code: 21215
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
18b. Kind of Business/Industry: Maintenance

17. Father's Name (First, Middle, Last): Herman H. Blaney
18. Mother's Name (First, Middle, Maiden Surname): Catherine E. Armager

19a. Informant's Name/Relationship (Type, Print): Ronald H. Blaney Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1555 Stone Chapel Road New Windsor, MD 21776

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: December 29 2001
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: James B Coulter
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bilateral Pneumonia.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Dehydration.
Due to (or as a consequence of):
c. Alzheimer's, Dementia
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent et time of deeth 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.
Poor P.O intake
HTN. Depression. Bladder
Tumor c Prostate Ulcer

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Menner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: S. Saving MD
29c. License number: D30119
29d. Date signed (Month, Dey, Yeer): 12-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHANNON STODDIOT 6212 Sykesville Road Sykesville 21784

State Registrar

31. Date filed (Month, Day, Yeer): DEC 26 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

6
USA
CRW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For Stata Ragistrar

Reg. No. 2001 42577

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William Samuel Black, Sr.	December 20, 2001	5:00 p. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3106 Maiden Lane	Manchester	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-42-1660	1☒ M 2☐ F	61 Yrs.			Sept. 26, 1940	Manchester, Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Carroll	Manchester	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3106 Maiden Lane P.O. Box 387	21102	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Punch-press operator	Black & Decker

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Henry Black, Jr.	Gladys Bowman Hale

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Black - wife	3106 Maiden Lane P.O. Box 387 Manchester, Md. 21102

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	New Lutheran Cemetery	Dec. 24, 2001	Manchester, Md.

21. Signature of Funeral Service Licensee: Justin R. Eichhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Lung cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None Known

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	26a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to tha cause(s) and manner stated.

29b. Signatura and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Howard Saiontz, M.D.	Md. # D 155552	12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard Saiontz, M.D. 555 S. Center St. Westminster, Md. 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

WJR 5

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42578

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Stella Beard

2. Date of Death (Month, Day, Year): December 16, 2001

3. Time of Death: 330p M

4a. Facility Name (If not institution, give street and number): LORIEN @ RIVERSIDE

4b. City, Town, or Location of Death: BELCAMP

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 214-20-7991

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 16, 1924

9. Birthplace (State or Foreign Country): District Of Columbia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3016 Goat Hill Road

10f. Zip Code: 21015

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Clerk

16b. Kind of Business/Industry: Clothing Manufacturer

17. Father's Name (First, Middle, Last): Iver Sylvester Taylor

18. Mother's Name (First, Middle, Maiden Surname): Lillian Elizabeth Mueller

19a. Informant's Name/Relationship (Type, Print): Earl David Beard / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3016 Goat Hill Road, Bel Air, MD 21015

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Holly Hill Mem. Grdns

Date: 12-19-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Holly McComas Remsberg

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular disease

Due to (or as a consequence of):

b. Renal failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Dehydration

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: JT Lee MD

29c. License number: D2066

29d. Date signed (Month, Day, Year): 12/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J T Lee MD. 698 Revolution St. Havre de Grace MD. 21078

State Registrar

31. Date filed (Month, Day, Year): DEC 18 2001

32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Margaret S. Beard

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42579

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Frances E. Best	December 23 2001	5:45 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Homewood at Crumland Farms	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-10-0905	1☐M 2☒F	86 Yrs.			April 24, 1915	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6941 North Clifton Road	21702	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert Fogle	Carrie Welty

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paul F. Fogle/Brother	6941 North Clifton Road, Frederick, Maryland, 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Olivet Cemetery	12-26-2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ P. Ryan McMillion MO1202	Keeney and Basford P.A. Funeral Home 106 E. Church St. Frederick, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Pneumonia	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Hip Fracture	One Week
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Esophageal Mass

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	12-14-2001	5:55 P M	1☐Yes 2☒No	Subject fell while walking

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Nursing Home	7407 Willow Road Frederick, Maryland

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Andrew Zarick Jr.	D35164	December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Zarick, Jr., M.D., 1080 West Patrick Street, Frederick, Maryland, 21703

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Denise B Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42580

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DONALD LINDBERGH BISER	December 26, 2001	9:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Glade Valley Nursing & Rehabilitation Ctr.	Walkersville	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-22-8365	1[X] M 2[ ] F	74 Yrs.			May 23, 1927	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Thurmont	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
107 Orchard Drive	21788	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: WWII	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Machine Operator & Laborer	Moore's Business Forms

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Walter Biser	Jennie Catherine Marker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dulcie Biser (Wife)	107 Orchard Drive, Thurmont, Maryland 21788

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Graceham Cemetery	12/29/01	Graceham, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic cerebrovascular disease	6 mo
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner? 1[ ] Yes 2[X] No

28. Place of Death (Check only one): Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA; Other: 4[X] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death: 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D31058	12/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gene F. Ashe, MD Woodsboro Medical Center, Woodsboro, Maryland 21798

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42581

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPHINE VERONICA BAILEY

2. Date of Death (Month, Dey, Yeer): 12 02 01

3. Time of Death: 8:40 pm

4e. Facility Neme *(If not institution, give street and number)*: The Pines Genesis Eldercare

4b. City, Town, or Location of Deeth: Easton

4c. County of Deeth: Talbot

Funeral Director

5. Social Security Number: 220-22-9761

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: 2/12/1928

9. Birthplece *(Stete or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. Stete: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 640 MECKLENBURG AVENUE APT. 315

10f. Zip Code: 21601

10g. Citizen of What Country?: U.S.A.

11. Merital Stetus: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: CLERK

16b. Kind of Business/Industry: MOTOR VEHICLE ADMINISTRATION

17. Father's Name *(First, Middle, Last)*: FRANK MIEDZIENOWSKI

18. Mother's Name *(First, Middle, Meiden Surneme)*: VERONICA ASSODOWSKA

19a. Informant's Neme/Relationship *(Type, Print)*: JOANNE BAILEY / DAUGHTER

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 222 PENNY LANE STEVENSVILLE, MARYLAND 21666

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: CHESAPEAKE CREMATION CTR.

Dete: 12/5/01

20c. Location - City or Town, Stete: STEVENSVILLE, MARYLAND

21. Signeture of Funeral Service Licensee: Thomas K. Helfenbein

22. Neme and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MARYLAND 21619

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Carcinoma of gallbladder, metastatic — years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end msnner es stated. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier:

29c. License number: D25933

29d. Dete signed *(Month, Dey, Yeer)*: 12-3-01

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): DR. PATRICK STERLING 508 IDLEWILD AVENUE EASTON, MARYLAND 21601

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 0 6 2001

32. Registrer's Signeture: Benna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Josephine Bailey
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42582

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shelton Ellis Brown JR.
2. Date of Death (Month, Day, Year): Dec. 18 2001
3. Time of Death: 10:45 P.M.
4a. Facility Name (If not institution, give street and number): Chesapeake Woods
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 218-40-7342
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 29,1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1002-Washington Street
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12a. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Linesman
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Shelton Brown, SR.
18. Mother's Name (First, Middle, Maiden Surname): Lena Mae Dashields

19a. Informant's Name/Relationship (Type, Print): Judy Brown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1002-Washington Street Cambridge, Maryland 21613

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Cambridge Crematory | Date: 12/20/2001
20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St, Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	metastatic Lung Cancer	three months
Due to (or as a consequence ot): b.	Lung Cancer	three months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence ot): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion ot ceuse ot death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place ot Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner ot Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time ot Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best ot my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: Lois A. Nam D.O.
29c. License number: H-14615
29d. Date signed (Month, Day, Year): 12/20/01

30. Name and address ot person who completed ceuse of death (Item 23a) (Type, Print): Lois A. Nam D.O. 100 Bramble Cambridge MD 21613

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001
32. Registrer's Signeture: Geneva G. Smith

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 42583

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Minnie Clark

2. Data of Death Month Day Year: December 28, 2001

3. Time of Death: 8:35 a.m.

4a Facility Name (If not institution, give street and number): Beverly Health Care

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-01-3715

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Dec. 4, 1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 750 Dual Highway

10f. Zip Code: 21740

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Dates:

13. Was Decedenf of Hispanic Origin? (Specify Yas or No- ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highast grade complated): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): none

16b. Kind of Business/Industry

17. Fathar's Nama (First, Middla, Last): unknown

18. Mothar's Nama (First, Middla, Maidan Surnama): unknown

19a. Informant's Name/Ralationship (Type, Print): Raymond C. Clark - son

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): Box 198, Barton, Maryland 21521

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)

20b. Piaca of Disposition (Nama of camatary, cramatory or othar placa): Hagerstown Crematory

Data: Dec. 30, 2001

20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Fred L Wantz

22. Nama and Addrass of Facility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that ceused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath):

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — MINS.

Dua to (or as a consaquanca of):

b. DEMENTIA — 10 yrs.

Sequantially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician**: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to tha causa(s) and mannar stated.

29b. Signature and titla of certifiar: Mayan J. Shafi

29c. License number: D28365

29d. Data signed (Month, Day, Year): 12.28.01.

30. Nama and addrass of parson who compilatad causa of daath (Item 23a) (Type, Print): MAWZAR J. SHAFI. 368 Mill Street-Hagerstown MD 21740.

State Registrar

31. Date filed (Month, Day, Year): DEC 3 1 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42584

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Roy Homer CONRAD

2. Date of Death Month / Day / Year: December 26 2001

3. Time of Death: 11:45

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-16-1169

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 4 1925

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 151 Chantilly Court

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Rep.

16b. Kind of Business/Industry: Meat Company

17. Father's Name *(First, Middle, Last)*: Homer Conrad

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Shank

19a. Informant's Name/Relationship *(Type, Print)*: Arlene Conrad - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 151 Chantilly Court Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hagerstown Crematory

Date: 12/31/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Munnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Conrad, Roy, 12/26 December 26, 2001 1145

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — 4W

Due to (or as a consequence of):
b. DIABETES MELLITIS — 15Y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. HYPERTENSION — 15Y

Due to (or as a consequence of):
d. PARKINSONS DISEASE — 5Y

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEIZER DISORDER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D52323

29d. Date signed *(Month, Day, Year)*: 12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Waseem 19414 C Heitersburg Pike Hagerstown Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

NAME: CONRAD,ROY HOMER DOS: 12/07/2001
12/04/1925 76 / M WASEEM, M. KHALID

H3043880081

H057073

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42585

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Donald Gerald Canfield, Sr.

2. Dete of Deeth — Month: December; Dey: 24; Yeer: 2001

3. Time of Deeth: 2338

4e Facility Neme *(If not institution, give street end number)*: Washington County Hospital

4b. City, Town, or Location of Deeth: Hagerstown

4c. County of Deeth: WASHINGTON

Funeral Director

5. Sociel Security Number: 217-30-7292

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthday)*: 66 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Nov. 10, 1935

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Washington

10c. City, Town or Location: Sharpsburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 18424 Mansfield Rd.

10f. Zip Code: 21782

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes: 1953-1957

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 0

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist

16b. Kind of Business/Industry: Foundry

17. Fether's Neme *(First, Middle, Last)*: Robert Vaughn Canfield

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Hazel Irene Churchey

19e. Informent's Neme/Reletionship *(Type, Print)*: Iva Lucille Canfield (wife)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 18424 Mansfield Rd. Sharpsburg, MD 21782

20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Smithsburg Crematory

Dete: Dec. 26, 2001

20c. Location - City or Town, Stete: Smithsburg, MD 21783

21. Signeture of Fiduciery Service Licensee: Myra M. Osborne

22. Neme end Address of Fecility: OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart teilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	Acute myocardial infarct	1 hour
Due to (or as a consequence of):		
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last b.	Diabetes Mellitus	>10 years
Due to (or as e consequence of):		
c.	Hypertension	>5 years
Due to (or as e consequence of):		
d.		

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the ceuse of deeth? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Plece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [X] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the besis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Samuel Chan, MD

29c. License number: D36655

29d. Dete signed *(Month, Dey, Yeer)*: Dec. 25, 2001

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): 1185 Mt. Aetna Rd. Hagerstown, MD 21740

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 26 2001

32. Registrar's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3043943871

Amended Item #5, Per F.D. 12/27/2001, Carroll County, cew

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 23A Part I

Per Physician, 01/02/2002 Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42586

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
TERESA		COSTANTINO	DEC. 21, 2001	4:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. CATHERINES NURSING HOME	EMMITSBURG	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~067-05-2449~~ 067-05-2445	1☐ M 2☒ F	91 Yrs.			08/05/1910	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	BALTIMORE	REISTERSTOWN	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10 DURKEE FARM RD.	21136	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	6	SECRETARY	

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GUIDO LOCATELLI	ROSETTA ALBERTUCCI

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NICHOLAS COSTALAS	10 DURKEE FARM RD., REISTERSTOWN, MD. 21136

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☒ Other (Specify) ENTOMBMENT	ST. JOSEPH CEMETERY	12/26/01	HACKENSACK, NJ.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R Jay Fletcher	FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. FAILURE TO THRIVE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ALZHEIMER'S DEMENTIA

Due to (or as a consequence of):
c. DEPRESSION

Due to (or as a consequence of):
d. G.E.R.D.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~ALZHEIMER'S DEMENTIA~~

~~DEPRESSION~~

~~GERD~~

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D0054580	12/22/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WASIM FAKHAR, M.D. 417 E BALT ST # D, TANEYTOWN MD 21787

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

18 52

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

12/21/2001 Carroll County, wj1

Amend Item 23a Part I line b, per Physician

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 42587

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys Isabelle Coombs
2. Date of Death Month Day Year: December 19, 2001
3. Time of Death: 12:30 pm
4a. Facility Name *(If not institution, give street and number)*: 4942 Shaffer Mill Road
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-26-9224 A
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 16, 1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Manchester
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4942 Shaffer Mill Road
10f. Zip Code: 21102
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner
16b. Kind of Business/Industry: Tavern

17. Father's Name *(First, Middle, Last)*: Harry Merriken
18. Mother's Name *(First, Middle, Maiden Surname)*: Hilda Spicer

19a. Informant's Name/Relationship *(Type, Print)*: Kelly S. Kelly, grandaughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4942 Shaffer Mill Road, Manchester, MD 21102

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Black Rock Cemetery
Date: 12/22 2001
20c. Location - City or Town, State: Butler, MD

21. Signature of Funeral Service Licensee: ▶ Steven W Eline M00723
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last
b. Diabetes Mellitus — 1984

Due to (or as a consequence of):
c.

Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~Diabetes Mellitus since 1984~~

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ [signature]
29c. License number: 040223
29d. Date signed *(Month, Day, Year)*: 12/20/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Goedeke MD 4231 N. Woods Trail Hampsted MD 21074

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 2001
32. Registrer's Signature: ▶ Geneva B Sparks

WJL 7

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42588

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): June (NMN) Conley

2. Date of Death: Month December Day 13 Year 2001

3. Time of Death: 11:50 AM

4a. Facility Name (If not Institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 235-26-5431

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun. 14, 1927

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12701 Eastern Avenue Extended

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert Flummer Bailey

18. Mother's Name (First, Middle, Maiden Surname): Bertha Adeline Miller

19a. Informant's Name/Relationship (Type, Print): Delbert L. Conley/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 131, Chase, MD 21027

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus

Date: 12/17/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Charles A. Engel

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Conley, June

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Septic Shock	1 day
Due to (or as a consequence of):	b. Poorly differentiated adenocarcinoma of the liver	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Moses N. Izuegbu MD

29c. License number: P15682

29d. Date signed (Month, Day, Year): December 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Moses Izuegbu 9000 Franklin Square Drive Baltimore MD, 21237

4

State Registrar

31. Date filed (Month, Day, Year): DEC 18 2001

32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42589

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harry Landon Christopher

2. Date of Death Month / Day / Year: December 14, 2001

3. Time of Death: 1108

4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-42-5999

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 3, 1945

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Perryman

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 427 Busby Drive

10f. Zip Code: 21130

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Heavy Equipment Operator

16b. Kind of Business/Industry: Heavy Equipment

17. Father's Name *(First, Middle, Last)*: John L. Christopher, Jr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Pippin

19a. Informant's Name/Relationship *(Type, Print)*: Margaret J. Christopher (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 427 Busby Drive, Perryman, Maryland 21130

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Spesutia Cemetery — Date: 12/18/01

20c. Location - City or Town, State: Perryman, Maryland

21. Signature of Funeral Service Licensee: Frank S. Zellers II

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. neurodiagenic pulmonary edema — 4 days

Due to (or as a consequence of): b. sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cardiomyopathy pancreatic carcinoma with metastases pancytopenia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D31712

29d. Date signed *(Month, Day, Year)*: 12/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES ECK JR 219 BELAIR AVE. ABERDEEN, MD 210

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 18 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42590

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beverly Ann Cusick

2. Date of Death (Month, Day, Year): Dec 19 2001

3. Time of Death: 7 45 pm

4a. Facility Name (If not institution, give street and number): 5015 Marshyhope Road

4b. City, Town, or Location of Death: Hurlock

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 217-28-4483

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 8 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Hurlock

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5015 Marshyhope Road

10f. Zip Code: 21643

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Jacob Edward Johnson

18. Mother's Name (First, Middle, Maiden Surname): Maude Smith

19a. Informant's Name/Relationship (Type, Print): Charles F. Cusick Sr.-husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5015 Marshyhope Road, Hurlock, MD 21643

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery | Date: 12/24

20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: John L. Thomas

22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer — 3 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Faulkner MD

29c. License number: D26388

29d. Date signed (Month, Day, Year): Dec 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Faulkner MD 302 Collins Ave Hurlock Md 21643

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001

32. Registrar's Signature: Donna L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42591

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Maryann	Demarr		December 29th, 2001	02:45 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	None

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-40-8095	1☐ M 2☒ F	71 Yrs.			MAY 26, 1930	MICHIGAN

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	PRINCE GEORGE'S	WALDORF	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3521 ACCOKEEK ROAD	20601	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	ELEMENTARY SCHOOL TEACHER	EDUCATION/P.G. COUNTY SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
EDWIN AUCKLAND BOWEN	FRANCES NEUGEBAUER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DEBORAH G. GRIGSBY/DAUGHTER	3986 SHAMROCK LANE, PORT REPUBLIC, MARYLAND 20676

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	TRINITY MEMORIAL GARDENS	01/03/2002	WALDORF, MARYLAND

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
JPK ▶ JOHN P. KNISLEY	M01164	THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. cognitive decline	3 weeks
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☒ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ (Wolfgang Boecker, MD)	26489, RES-000	December 29th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wolfgang Boecker, MD, 600 North Wolfe Street, Baltimore, Maryland 21205

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
DEC 31 2001	

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amend Item#1 perPHYG803 1/15/02 EW

Reg. No: 2001 42592

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~William Edward Dorsey~~ William Edward Dorsey

2. Date of Death (Month, Day, Year): December 29, 2001

3. Time of Death: 11:30AM

4a. Facility Name (If not institution, give street and number): Western Maryland Hospital Center

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-36-6610

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 7, 1921

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: BOONSBORO

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 103 MAPLE AVENUE

10f. Zip Code: 21713

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMER

16b. Kind of Business/Industry: DAIRY FARMER

17. Father's Name (First, Middle, Last): WILLIAM GRAVES DORSEY

18. Mother's Name (First, Middle, Maiden Surname): BEULAH M. HAMMERSLA

19a. Informant's Name/Relationship (Type, Print): MARY E. DORSEY, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 MAPLE AVENUE, BOONSBORO, MARYLAND 21713

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MANOR CEMETERY

Date: JAN. 3, 2002

20c. Location - City or Town, State: BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee: Kelly A. Zimmerman

22. Name and Address of Facility: BAST FUNERALHOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SEPTICEMIA — ONE WEEK

Due to (or as a consequence of):
b. PNEUMONIA — ONE MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. MYOCARDIAL INFARCTION — ONE MONTH

Due to (or as a consequence of):
d. ATRIAL FIBRILLATION — YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

PERIPHRAL NEUROPATHY

PERIPHRAL VASCULAR DISEASE.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D44996

29d. Date signed (Month, Day, Year): December 29, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ZAFAR MALIK MD 1500 PENNSYLVANIA AVE. HAGERSTOWN MARYLAND 21740

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001

32. Registrar's Signature: [illegible] Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42593

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Marc Frederick Dailey	December 21 2001	23:40 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-72-8595	1☒M 2☐F	43 Yrs.			April 7, 1958	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Washington	Hagerstown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
216 Potomac Heights	21742	U.S.A

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Sales	Jewelry Store

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Donald Richard Dailey	Helen N. Kephart

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Stacy Dailey (Sister)	216 Potomac Heights Hagerstown, Md. 21742

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State
1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Smithsburg Crematory	Dec. 22, 2001	Smithsburg, Md.

21. Signature of Funeral Service Licensee: ▶ Dennis L. Davis

22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	END STAGE HEPATORENAL SYNDROME	1 MONTH
Due to (or as e consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	ALCOHOLIC HEPATITIS	6 Weeks
Due to (or as a consequence of):		
c.	ALCOHOLISM	15 YEARS
Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Dete of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of deeth? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deelh occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ FAMILY PHYSICIAN	D17067	12/22/2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN E. METZNER, M.D. 749 NORTHERN AVE. HAGERSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Benna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Marc Frederick Dailey

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42594

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Elizabeth Deneen

2. Date of Death: Month December Day 20 Year 2001

3. Time of Death: 1600

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-10-7554

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 19, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11148 Lakeside Drive

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Parts Checker

16b. Kind of Business/Industry: Automotive

17. Father's Name *(First, Middle, Last)*: Benjamin William Demoss

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Elizabeth Shinholtz

19a. Informant's Name/Relationship *(Type, Print)*: Ernest B. Deneen / Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 143 Spur Road, Martinsburg, WV 25401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Buck Valley Christian Church Cem. Date: 12/22/01

20c. Location - City or Town, State: Warfordsburg, PA

21. Signeture of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac St., Hagerstown, MD 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. Approximate Intervel Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIO VASCULAR DISEASE MINS.

Due to (or as a consequence of):

b. GASTRO INTESTINAL BLEEDING 6 hours.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other eignificant conditione** contributing to death but not resulting in the underlying ceuse given in Part t.

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicet examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) end menner as stated. 2☐ **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ [signature]

29c. License number: D 28365

29d. Date signed *(Month, Dey, Year)*: 12-21-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANZAR J. SHAFI. 368 MILLS STREET HAGERSTOWN MD 21740.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 26 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Deneen, Mary Elizabeth

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42595

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edna Blane Dixon
2. Date of Death (Month, Day, Year): December 16, 2001
3. Time of Death: 1:00 P.M.
4a. Facility Name (If not institution, give street and number): 22012 Holiday Dr.
4b. City, Town, or Location of Death: Smithsburg
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 163-09-3813
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 12, 1917
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 22012 Holiday Dr.
10f. Zip Code: 21783
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Charles Wachter Brown
18. Mother's Name (First, Middle, Maiden Surname): Esther Blane McGlaughin

19a. Informant's Name/Relationship (Type, Print): Wayne W. Dixon (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 S. Conococheague St. Williamsport, Md. 21795

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: Dec. 18, 2001
20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis
22. Name and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. HYPOTENSION — Hours

Due to (or as a consequence of):
b. BILATERAL FEMORAL FRACTURE — 6 WKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. SEVERE AORTIC STENOSIS AND — MONTHS
Due to (or as a consequence of):
d. PULMONARY HYPERTENSION

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIASTOLIC DYSFUNCTION. MITRAL AND TRICUSPID INSUFFICIENCY. HYPOTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: [signature] FAMILY PHYSICIAN
29c. License number: D17067
29d. Date signed (Month, Day, Year): 12/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN E. MCEVOY, MD 747 NORTHERN AVE HAGERSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 20 2001
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42596

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THEODORE GAER DAVIS, JR.

2. Date of Death (Month, Day, Year): DECEMBER 27, 2001

3. Time of Death: 4:16 PM

4a. Facility Name *(If not institution, give street and number)*: SOUTHERN MARYLAND HOSPITAL CENTER

4b. City, Town, or Location of Death: CLINTON

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 217-32-2710

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 4, 1938

9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: NANJEMOY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2805 SUNNYVIEW PLACE

10f. Zip Code: 20662

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Year or Datas: 1953-1957

13. Was Decedenf of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, Whifa, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedant's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: AUTOMOBILE/HEAVY EQUIP. MECHANIC

16b. Kind of Business/Industry: CHARLES COUNTY PUBLIC SCHOOLS

17. Fathar's Name *(First, Middla, Last)*: THEODORE GAER DAVIS, SR.

18. Mother's Nama *(First, Middle, Maiden Surname)*: GLADYS P. SNYDER

19a. Informant's Name/Relationship *(Type, Print)*: CATHERINE C. DAVIS/WIFE

19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 124, NANJEMOY, MARYLAND 20662

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: OLD FIELDS EPISCOPAL CHURCH

Date: 12/31/2001

20c. Location - City or Town, State: HUGHESVILLE, MD

21. Signature of Funeral Service Licensee: JPK ▶ JOHN P. KNISLEY M01164

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on each line.

Approximate Interval Batween Onsef and Death

Immediate Causa (Final disease or condition rasulting in death)

a. Metastatic Cancer — Mo

Dua to (or as a consequanca of):

b. Cancer Prostate — Mos

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availabla prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Placa of Death *(Check only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straet, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stafed.

29b. Signafure and fitla of certifier: ▶ Thomas L. Fielding DO

29c. Licensa number: D001923

29d. Data signed *(Month, Day, Year)*: Dec 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T.L. Fieldson MD Waldorf MD 20601

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 31 2001

32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42597

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary R. Dowling
2. Date of Death: Month 12 Day 23 Year 2001
3. Time of Death: 5:31 PM
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 213-55-7867
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 2 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 20 1999
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 9024 CLOVE CT
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NONE
16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): BRIAN EUGENE DOWLING
18. Mother's Name (First, Middle, Maiden Surname): MARY MICHELE DICK

19a. Informant's Name/Relationship (Type, Print): BRIAN E. DOWLING/FATHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9024 CLOVE CT EASTON, MD 21601

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN MEMORIAL PARK
Date: 12-29-01
20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: ▶ JOHN R MERCERON
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebral herniation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. obstructive hydrocephalus
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Courtney L Roberts MD
29c. License number: D0055069
29d. Date signed (Month, Day, Year): 12/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 22 South Greene St. #S5018 Baltimore, Maryland 21201 Courtney L. Roberts, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBB

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42598

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
FREDA M. DOWDY	December 25, 2001	1914 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-01-5963	1☐M 2☒F	86 Yrs.			OCT 20 1915	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	TALBOT	EASTON	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7289 FRANCES ST	21601	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	0	CASHIER	GROCERY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES COOPER	A. FLORENCE HADDAWAY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
F. IRENE STERLING/DAUGHTER	7289 FRANCES ST., EASTON, MD 21601

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	NEAVITT CEMETERY	12-28-01	NEAVITT, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶M.E. Newnam III CFSP	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral hemorrhage	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Hypertensive Cerebro-vascular Disease	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28l. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	H41818	December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICK STERLING D.O. 508 IDLEWILD AVE, EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Donna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Freda Dowdy

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-l show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBB

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42599

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Helen Droll

2. Date of Death: Month December Day 23 Year 2001

3. Time of Death: 10:50 PM

4a. Facility Name (If not institution, give street end number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-01-1506

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, 1915

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6010 Eurith Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): William Oelschlager

18. Mother's Neme (First, Middle, Meiden Surname): Margaret Junker

19a. Informent's Neme/Reletionship (Type, Print): Joseph B. Droll / Husband

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6010 Eurith Ave. Baltimore, MD 21206

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Resthaven Crematory | Date: Dec. 24, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee ▶

22. Neme end Address of Facility: Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
e. Respiratory Failure — Years

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last
b. Chronic Obstructive Pulmonary Disease — Years

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier ▶ M.D

29c. License number: D26499

29d. Date signed (Month, Day, Year): 12-24-01

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Ronald E. Miller, M.D. 4 Culwell St. Mt. Airy, MD 21771

10

State Registrar

31. Dete filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signeture ▶ Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended
Item #23a.
Line a./WCHD/SC
Per Phys./12-20-2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 42600

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ivanline Elizabeth Early	December 17, 2001	10:35AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
15009 Sabillasville Rd.	Thurmont	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
488-05-2990	1☐ M 2☒ F	82 Yrs.			April 8, 1919	Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Frederick	Thurmont	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15009 Sabillasville Rd.	21788	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ivan Coultas	Charlene Goodner

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dawn Early (Daughter)	15009 Sabillasville Rd. Thurmont, Md. 21788

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Smithsburg Crematory	Dec. 18, 2001	Smithsburg, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dennis K. Davis	Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the daath. Do not enter tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Lisl only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disaasa or condition resulting in death)	a. ~~ASCVD~~ Arteriosclerotic Cardiovascular Disease	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated evenls resulting in death) Last	b.	
	Due to (or es a consequenca of):	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only o...)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as steted.
2☒ **Medical Examiner:** On the besis ot exemination end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dala signed (Month, Day, Year)
▶ Andrew Zarick Jr MD	D35164	December 17, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Zarick Jr MD 1080 W Patrick St, Frederick, MD 21703

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 2001	▶ G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: A... this certificate has been signed by tha attending physician and completely filled in by the funeral director, page 2 should be detached for usa as tha burial-transit

To Be Completed by Funeral Director

Medical C...cation: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42601

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace Claudia Erline
2. Date of Death (Month, Day, Year): December 15, 2001
3. Time of Death: 10:30 A M
4a. Facility Name (If not institution, give street and number): 4823 Orville Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-20-7300
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 3, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4823 Orville Avenue
10f. Zip Code: 21205
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Warehouse Worker
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): William Luther Shoemaker
18. Mother's Name (First, Middle, Maiden Surname): Glendore Sullivan

19a. Informant's Name/Relationship (Type, Print): Susan M. Cash (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5053 Wright Avenue, Baltimore, Maryland 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith
Date: 12/20/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark T. [illegible]
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Right Pleural Effusion

Due to (or as a consequence of):
b. Mediastinal Mass — Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Tobacco Abuse
Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D34146
29d. Date signed (Month, Day, Year): 12/17/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Murray West, 3301 Belair Road, Baltimore, Maryland 21213

State Registrar

31. Date filed (Month, Day, Year): DEC 18 2001
32. Registrar's Signature: ▶ Penny G Sparks

DHMH t7 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42602

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Anna Elliott

2. Date of Death: Month Dec. Day 20 Year 2001

3. Time of Death: 6:22AM

4a. Facility Name (If not institution, give street and number): Magnolia Hall Nursing & Rehabilitation Ct.

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 222-05-4349

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 13, 1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 413 Calvert Street

10f. Zip Code: 21620

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker

16b. Kind of Business/Industry: Someone else's home

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): Lillian Davis

19a. Informant's Name/Relationship (Type, Print): Charles William Elliott/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 413 Calvert St., Chestertown, Maryland 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bordley Chapel Church Cem | Date: 12/29/01

20c. Location - City or Town, State: Pondtown, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Bennie Smith Funeral Home, Roar 298, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute CVA — 24 Hours

Due to (or as a consequence of):
b. HCVD — 20 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ John C. Seymour MD

29c. License number: D-0013824

29d. Date signed (Month, Day, Year): 12-21-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Seymour, MD, 122 Speer Road, Chestertown, Maryland 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42603

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John M. Franck
2. Date of Death Month / Day / Year: DECEMBER 15 2001
3. Time of Death: 4:05 PM
4a. Facility Name *(If not institution, give street and number)*: SAINT JOSEPH MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON, MARYLAND
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-07-6454
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 18, 1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12D Brook Farm Court
10f. Zip Code: 21128
10g. Citizen of What Country?: U. S. A.

11. Meritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: 1945
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Combustion Engineer
16b. Kind of Business/Industry: Steel Company

17. Fether's Neme *(First, Middle, Last)*: Ross Franck
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice McLaughlin

19a. Informent's Neme/Reletionship *(Type, Print)*: Mr. R. Ross Franck (Son)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 12D Brook Farm Court, Perry Hall, Maryland 21128

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Maryland Veterans Cemetery
Date: 12/19/01
20c. Location - City or Town, State: Owings Mills, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A. Wellen
22. Name and Address of Facility: Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line. — Approximete Intervel Between Onset end Death

Immediete Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest
b. Due to (or as a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other stgnificant conditions** contributing to death but not resulting in the underlying ceuse given in Pert t.: ATRIAL FIBRILLATION; AORTIC STENOSIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Deeth *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: ▶ [signature]
29c. License number: D37254
29d. Date signed *(Month, Day, Year)*: 12/18/01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): BOON P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 18 2001
32. Registrar's Signeture: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42604

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth GROVE
2. Date of Death Month / Day / Year: December 29, 2001
3. Time of Death: 12:25 P.M.
4a. Facility Name *(If not institution, give street and number)*: Beverly Healthcare
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-16-3796
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 3, 1922
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 478 Pangborn Blvd.
10f. Zip Code: 21742
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedant's Usuel Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Assembler
16b. Kind of Business/Industry: Window Manufacturer

17. Father's Nama *(First, Middla, Last)*: Russell Mathias
18. Mothar's Name *(First, Middle, Maiden Surneme)*: Sarah Eller

19a. Informant's Neme/Reletionship *(Type, Print)*: Carolyn Miller | Daughter
19b. Mailing Addrass *(Street end Number or Rural Route Number, City or Town, Steta, Zip Code)*: 478 Pangborn Blvd. Hagerstown, MD 21742

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other pleca)*: Mt. View Cemetery
Date: January 3, 2002
20c. Location - City or Town, Stata: Sharpsburg, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Fecility: Osborne Funeral Home, 425 S. Conococheague St. Williamsport, MD 21795

Physician /Medical Examiner

23a. Pert1. Enter the diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximata Interval Between Onset end Deeth

Immediata Cause (Final disaasa or condition resulting in daath)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — MINS
Due to (or es a consequence of):
b. CONGESTIVE HEART FAILURE — 3 MONTHS
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last
Due to (or es e consequanca of):
c.
Dua to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No
26. Placa of Death *(Check only ona)*: Hospitel: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Neturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Data of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledga, death occurred at tha tima, data and place, and dua to the cause(s) and mennar es stated. 2☐ **Medical Examiner:** On tha basis of examinetion end/or investigetion, in my opinion, daeth occurred at tha time, data and place, and due to the cause(s) and manner stated.

29b. Signature end titte of certifier: [signature]
29c. License number: D 28365
29d. Date signed *(Month, Dey, Year)*: 12.30.01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): MANZAR ISHAQ 368 MILL Street - Hagerstown MD 21740.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 2002
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42605

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIVIAN VIRGINIA GROVE
2. Date of Death (Month, Day, Year): December 23, 2001
3. Time of Death: 1:05 AM
4a. Facility Name (If not institution, give street and number): Avalon Manor Health Care Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-14-1510
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 300 Northern Avenue
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Kitchen Worker
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Charles Frederick Lum
18. Mother's Name (First, Middle, Maiden Surname): Lillie Mae Fish

19a. Informant's Name/Relationship (Type, Print): Irene E. Wentz Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1309 Cedarwood Drive, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery | Date: 12-27-2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: R. Noel Brady
22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	LUNG CANCER	5Y
Due to (or as a consequence of): b.	CORONARY ARTERY DISEASE	9Y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	HYPERTENSION	20Y
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D52323
29d. Date signed (Month, Day, Year): 12/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khalid Waseem, MD 19414C Leitersburg, Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: Linda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Grove Vivian

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 42606

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John W. Gartrell, Sr.	December 20 2001	5:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5100 Woodbine Road	Woodbine	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-24-8005	1☒M 2☐F	78 Yrs.			September 19, 1923	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Woodbine	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5100 Woodbine Road	21797	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th grade		Heavy Equipment Operator	A.G. Parrott Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Gartrell	Edith Hess

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Thomas Henry Gartrell son	1619 W. Old Liberty Road Winfield, MD 21784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lake View Mem. Park	December 24 2001	Sykesville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donna B Conaway	Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Atherosclerotic Cardiovascular Disease	> 2 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	Coronary Artery Disease	> 2 YRS
Due to (or as a consequence of): c.	DIABETES MELLITUS	> 1 YR
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☑Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☑Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Patrick Turner MD	D 20806	12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATRICK TURNER, MD 1000 LIBERTY ROAD ELDERSBURG MD 21784

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Jenna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

12 CCW

Amend Item 23a Part I Line b & c, per Physician, 12/21/2001 Carroll County, wjl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42607

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES THOMAS BLACKEN
2. Date of Death: Month 12 Day 19 Year 2001
3. Time of Death: 6:00PM
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 212-24-6722
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 28, 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll County
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2145 Albert Rill Road
10f. Zip Code: 21074
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): state highway worker
16b. Kind of Business/Industry: state highway dept.
17. Father's Name (First, Middle, Last): James Glacken
18. Mother's Name (First, Middle, Maiden Surname): Carrie Lookingbill
19a. Informant's Name/Relationship (Type, Print): Evelyn D. Glacken / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2145 Albert Rill Road Hampstead, Maryland 21074
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial Gdns.
Date: Dec. 22, 2001
20c. Location - City or Town, State: Finksburg, Maryland
21. Signature of Funeral Service Licensee: Alan C. Purvis M01072
22. Name and Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Fibrillation — 2 WKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): END STAGE CORONARY ARTERY DISEASE — 12 years
c. Due to (or as a consequence of): MYOCARDIAL INFARCTION — 6 Years
d. Due to (or as a consequence of): — 6 years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Khalil Frej MD
29c. License number: D 389 15
29d. Date signed (Month, Day, Year): 12/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KHALIL FREIJI MD 295 STONER Ave Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 10

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-7151-005

KEVIN GARMZABAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42608

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kevin Mehdi Garmzaban

2. Date of Death — Month: DECEMBER Day: 18 Year: 2001

3. Time of Death: 6:58P.M.

4e. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-23-2547

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 18 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jul 10, 1983

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Eldersburg

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6213 Longleaf Pine Road

10f. Zip Code: 21784

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student

16b. Kind of Business/Industry: College

17. Father's Name *(First, Middle, Last)*: Mehdi Garmzaban

18. Mother's Name *(First, Middle, Maiden Surname)*: Susan Kingure

19a. Informant's Name/Relationship *(Type, Print)*: Susan Songy, mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6213 Longleaf Pine Rd, Eldersburg, MD 21784

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hampstead Cemetery

Date: 12/22 2001

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Steven W Eline M00723

22. Name and Address of Facility: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gunshot Wound OF Chest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury *(Month, Day, Year)*: 12/18/01

28b. Time of Injury: 5:45 PM

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: Subject Shot

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Parking Lot

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Owings Mills Mall Baltimore County, Md.

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: DECEMBER 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42609

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn A. Ghirardi

2. Date of Death Month Day Year: December 15, 2001

3. Time of Death: 10:10 A.M.

4a Facility Name *(If not institution, give street and number)*: Laurel Wood Care Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 217-03-8177

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 10, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Perryville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1529 Frenchtown Road

10f. Zip Code: 21903

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): Unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress

16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Daniel Neary

18. Mother's Name *(First, Middle, Maiden Surname)*: Amy Reinhard

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Knight/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1529 Frenchtown Road Perryville, MD 21903

20a. Method of Disposition: ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Holly Hill Memorial Gdns.

Date: 12/18/01

20c. Location - City or Town, State: Baltimore,Maryland

21. Signature of Funeral Service Licensee: ▶ Amanda David

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 610 West Macphail Road Bel Air, MD 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE COPD

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residance 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D54073

29d. Data signed *(Month, Day, Year)*: 17 DEC 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arlen Stone, MD 817 Churchman's Cir Newcastle DE 19720

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 18 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CHIRARDI

Medical Certification: To Be Completed by Physician/Medical Examiner

01-7255-031
HERIBERTO GARCIE
CC Amend Item#14 perFHG803 1/16/02 EW
UNPENDED 011002:ITEMS#23a,27,28a-f per ME G803 ss

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42610

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HERIBERTO GARCIA
2. Date of Death (Month, Day, Year): DECEMBER 21, 2001
3. Time of Death: 2348 p
4e. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 144-68-7024
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 36 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 14, 1965
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1135 Providence Court
10f. Zip Code: 21703
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: Puerto Rican
14. Race - American Indian, Black, White, etc. Specify: White ~~Hispanic~~

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Installer
16b. Kind of Business/Industry: office equipment

17. Father's Name (First, Middle, Last): Rafael Garcia
18. Mother's Name (First, Middle, Maiden Surname): Victoria Cabrera

19a. Informant's Name/Relationship (Type, Print): Rafael Garcia / father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1135 Providence Ct., Frederick, MD 21703

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glade Cemetery
Date: 12/27/01
20c. Location - City or Town, State: Walkersville, MD

21. Signature of Funeral Service Licensee: Jacqueline Krec
22. Name and Address of Facility: Stauffer Funeral Homes, P.A.
1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year) Found: 12-21-01
28b. Time of Injury Found: 11:10p M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found in house
28f. Location (Street and Number or Rural Route Number, City or Town, State) 18608 Blue Violet Lane, Montgomery County, Maryland

29e. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. Titus
29c. License number: OCME
29d. Date signed (Month, Day, Year): DECEMBER 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-7365-031
Christopher R. Herbaugh
TLC

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42611

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Christopher Ryan Herbaugh

2. Date of Death Month Day Year: December 29, 2001

3. Time of Death: 21:14 p.m.

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-02-3118

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 35 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 22, 1966

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 18505 Nathan Court

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 6

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teachers Assistant

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Gregory Lafayette Herbaugh

18. Mother's Name *(First, Middle, Maiden Surname)*: Judith Ann Swisher

19a. Informant's Name/Relationship *(Type, Print)*: Judy A. Herbaugh / Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3423 Woodland Drive, Edgewater, FL. 32141

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematorium

Date: 12/31/01

20c. Location - City or Town, State: Smithsburg, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac St. Hagerstown, MD 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hanging

Due to (or as a consequence of):
b. Depression

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 12-29-2001

28b. Time of Injury: 2050 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Shady Grove Hospital

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Adventist Hospital, Montgomery County, Maryland

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], M.D.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: December 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 2 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42612

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): GILBERT ABRAHAM HOLMES
2. Date of Death (Month, Day, Year): December 23 2001
3. Time of Death: 1840
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 220-09-8162
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 29, 1918
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: KEEDYSVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3804 TREGO MOUNTAIN ROAD
10f. Zip Code: 21756
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 | College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: COUNTY GOVERNMENT

17. Father's Name (First, Middle, Last): CLARENCE ABRAHAM HOLMES
18. Mother's Name (First, Middle, Maiden Surname): PEARL I. METZ

19a. Informant's Name/Relationship (Type, Print): PATRICIA A. HOLMES, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3804 TREGO MOUNTAIN ROAD, KEEDYSVILLE, MD 21756

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SAMPLES MANOR CEMETERY
Date: DEC. 28, 2001
20c. Location - City or Town, State: SHARPSBURG, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean
22. Name and Address of Facility: BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. pneumonia — Due to (or as a consequence of): — 48h

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: diabetes, organic brain syndrome

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Guedenet
29c. License number: D32518
29d. Date signed (Month, Day, Year): 12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Guedenet 100 Greeting Lane Keedysville Maryland

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Holmes, Gilbert Abraham
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42613

Colon B Humphrey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): COLON BEAMEN HUMPHREY				2. Date of Death (Month, Day, Year): Dec. 29, 2001	3. Time of Death: 2:28P M
4a. Facility Name (If not institution, give street and number): Civista Medical Center	4b. City, Town, or Location of Death: La Plata			4c. County of Death: Charles	
5. Social Security Number: 232-30-0973	6. Sex: 1☐M 2☒F	7. Age (In yrs. last birthday): 77 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): January 22, 1924	9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Charles	Welcome	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8281 Blossom Point Road	20693	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Equipment Specialist	Federal Govt.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Cleveland Humphrey	Elizabeth Rhodes Humphrey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rose Humphrey/Wife	8281 Blossom Point Rd. Welcome,MD. 20693

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Arlington National Cem.	1/14/02	Arlington,Va.

21. Signature of Funeral Service Licensee: David C. Echols M00945

22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Anoxic Encephalopathy.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. cardiac arrest S/P CPR	5 days.
	Due to (or as a consequence of): c. CAD	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Abbas Omais	D-57708	12/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Abbas Omais,MD 7C Post Office Rd. Waldorf, Md. 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 31 2001	Barbara G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42614

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond William Haney
2. Date of Death: Month December Day 11th Year 2001
3. Time of Death: 3.00 AM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 378-18-8105
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 24, 1919
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10e. State: District | 10b. County: of Columbia | 10c. City, Town or Location: Washington | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5425 33rd Street NW
10f. Zip Code: 20015
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer
18b. Kind of Business/Industry: Aeronautical

17. Father's Name (First, Middle, Last): Raymond Charles Haney
18. Mother's Name (First, Middle, Maiden Surname): Madeline Sophia Muller

19a. Informent's Name/Reletionship (Type, Print): Joan M. Romano - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5425 33rd Street NW, Washington, DC 20015

20a. Method of Disposition: 1 [X] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. | Date: 12-12-01
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finet disease or condition resulting in death): a. Acute Cholecystitis — Approximate Interval Between Onset and Death: Weeks

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Alzheimer's Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Ernestine Wright, MD
29c. License number: D52740
29d. Date signed (Month, Day, Year): December 11th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ernestine Wright, M.D. 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year): DEC 18 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 42615
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JAMES	E	Hoxter	DECEMBER 19, 2001	01:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-92-6982	1 [X] M 2 [ ] F	36 Yrs.					12/09/1965	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	QUEEN ANNE'S	CHESTER	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
907 AUCKLAND WAY	21619	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Sacondary (0-12)	College (1-4or 5+)		
	4	ADMINISTRATOR	GOVERNMENT

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maiden Surneme)
JAMES EDWARD HOXTER	PATRICIA NASH

19a. Informent's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
JAMES E. HOXTER, SR. / FATHER	504 PERRY'S CORNER ROAD GRASONVILLE, MD 21638

20a. Mathod of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Data	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Ramovat from State 4 [ ] Donation 5 [ ] Othar (Specify)	STEVENSVILLE CEMETERY	12/22/2001	STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Chad M. Fellows

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MARYLAND 21619

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)
a. HYPOXIA — 6 HRS

Due to (or as a consequence of):
b. ADult Respiratory distress SYNDROME — 3WKS

Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaase or injury that initiated avents resulting in death) Last

Dua to (or as a consequence of):
c. PNeumocystic CARINI PNeumoNIA — 4WEEKS

Due to (or as a consequence of):
d. HUMAN IMMUNODEFICIENCY VIRUS INFECTION — 8 YEARS

tF FEMALE: 23b. Was decedant pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fatat daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of daath 5 [ ] Othar (specify) 9 [ ] Unknown	23d. Date of dalivary Month Day Yaar

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pSeudomoNAS Sepsis

23e. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were autopsy findings available prior to complation of causa of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical axaminer? 1 [ ] Yes 2 [X] No	26. Place of Daath (Chack only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Rasidanca 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Naturat 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined		M	1 [ ] Yes 2 [ ] No	

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)	28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata)

29a. Cartifiar (Check only one)
1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha time, date and placa, and dua to the causa(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Yeer)
Berliner MD	RES-888	DECEMBER 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print): ADAM BERLINER, JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST, BALTIMORE MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#30 per PHYG803 1/23/02 EW

Certificate of Death

Reg. No. 2001 42616

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAROLD JAMES

2. Date of Death Month: DECEMBER Day: 21 Year: 2001

3. Time of Death: 10:42 PM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-30-2375

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 4, 1936

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17900 Carter Lane

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1955-60

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): truck driver

16b. Kind of Business/Industry: freight

17. Father's Name (First, Middle, Last): Frank A. James

18. Mother's Name (First, Middle, Maiden Surname): Gladys M. Youger

19a. Informant's Name/Relationship (Type, Print): Doris E. James - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17900 Carter Lane, Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery

Date: 12/27/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart tailure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d. Due to (or as e consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MYOCARDIAL INFARCTION

HYPERTENSION

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carnell Cooper, MD

29c. License number: D40886

29d. Date signed (Month, Day, Year): 12-21-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ~~DR. MICHAEL EBRIGHT,~~ 22 S. GREENE ST., BALTIMORE, MD 21201 Carnell Cooper, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 02 2002

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42617

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Arthur Jones

2. Date of Death (Month, Day, Year): DECEMBER 19, 2001

3. Time of Death: 5:30 AM

4a. Facility Name (If not institution, give street and number): RAVENWOOD LUTHERAN VILLAGE

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 217-10-2967

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 7, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 114 Buttercup Drive

10f. Zip Code: 21740

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer

16b. Kind of Business/Industry: Fairchild Industries

17. Father's Name (First, Middle, Last): John S. Jones

18. Mother's Name (First, Middle, Maiden Surname): Ella Mae Bowlus

19a. Informant's Name/Relationship (Type, Print): Virginia A. Jones-Geis/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2 East Poplar Funkstown, MD 21734

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Rest Haven Cemetery | Date: December 22 2001

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signeture of Funeral Service Licensee: Eric L. Brown

22. Name end Address of Facility: Rest Haven Funeral Chapel, 1601 Pennsylvania Ave. Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. LIVER CIRRHOSIS — 14 yrs.

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred et the tima, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Margaret Gray

29c. License number: D28365

29d. Date signed (Month, Day, Year): 12.19.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANZAR ISHAK. 368 MILL Street Hagerstown MD 21740

State Registrar

31. Date filed (Month, Dey, Year): DEC 2 1 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 225a.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JONES, PAUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42618

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Douglas Johnson, Jr.
2. Date of Death: Month 12 Day 20 Year 01
3. Time of Death: 9:35 AM
4a. Facility Name (If not institution, give street and number): Copper Ridge
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-26-0854
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 15 1922
9. Birthplace (State or Foreign Country): Pa.

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 106 Highland Road
10f. Zip Code: 21157
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): machinest
16b. Kind of Business/Industry: Telemechanique

17. Father's Name (First, Middle, Last): George Douglas Johnson Sr.
18. Mother's Name (First, Middle, Maiden Surname): Helen Elizabeth Anders

19a. Informant's Name/Relationship (Type, Print): David Johnson (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Highland Rd., Westminster, Md 21157

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation Srv.
Date: 12-21-01
20c. Location - City or Town, State: Sykesville, Md.

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimers Dementia	8 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert L. Mann, MD
29c. License number: 032882
29d. Date signed (Month, Day, Year): 12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Mann 114 Business Center Dr. Reisterstown, Md 21136

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL
1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42619

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN B. JACKSON
2. Date of Death Month Day Year: Dec. 15, 2001
3. Time of Death: 10:25 AM
4a. Facility Name (If not institution, give street and number): 2005 Beech St.
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 210-14-6811
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/23/1928
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Harofrd
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1 Yes XX No
10e. Street and Number: 2005 Beech St.
10f. Zip Code: 21015
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 XX Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 No If Yes, Give Year or Dates: 1950-52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Civil Service

17. Father's Name (First, Middle, Last): James JAckson
18. Mother's Name (First, Middle, Meiden Surname): Viola Whiteman

19a. Informant's Name/Relationship (Type, Print): Virginia E. Jackson-wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2005 Beech St., Bel Air, MD 21015

20a. Method of Disposition: 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Nebo Cemetery
Date: 12/18/2001
20c. Location - City or Town, State: Delta, PA

21. Signature of Funeral Service Licensee: John D. Tillett
22. Name and Address of Facility: Harkins F.H. Inc., 600 Main St., Delta, PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Non Small cell Lung Cancer
Due to (or as a consequence of):
b. Malignant left pleural Effusion — 3 months.
Due to (or as a consequence of):
c. Chronic obstructive lung Disease
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 XX No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 XX No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 XX Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B.D. Parekh
29c. License number: D0018424
29d. Date signed (Month, Day, Year): Dec. 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. B.D. Parekh, 1908 Harford Rd., Fallston, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 17 2001
32. Registrar's Signature: Jenna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42620

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
VIRGINIA	JONES	DECEMBER 26, 2001	6:15 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FREDERICK MEMORIAL HOSPITAL	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-18-5317	1☐M 2☒F	82 Yrs.			OCT 23, 1919	WASHINGTON, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	FREDERICK	WALKERSVILLE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
2820 WILDWOOD COURT	21793	UNITED STATES

11. Marital Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12	2	HOUSEWIFE	SELF

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
ELSWORTH C. COX	NELLIE RUTH ROWLEY

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WILLIAM JONES / SON	295 KENWOOD PLACE, WALKERSVILLE, MD 21793

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cramatory or other place)	Dete	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)	GEORGEWASHINGTONCEM.	12/31/01	ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee: Peter MacKay

22. Name and Address of Facility: STAUFFER FUNERAL HOMES, P.A. 1621 OPOSSUMTOWN PIKE, FREDERICK, MARYLAND 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. AORTIC THROMBOSIS	3 DAYS
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	Due to (or as e consequence of):	
	b. Due to (or es a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnency	23d. Dete of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

ANEMIA, DVT, DM, CVA, DEMENTIA ATRIAL FIB, GERD

23e. Did tobecco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were eutopsy findings availeble prior to completion of cause of death?
1☐Yes 2☐No 3☐Probebly 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Wes case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Locetion (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated.
2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurrad at the time, dete and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D21936	12/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. DONELSON MD 170 THOMAS JOHNSON DR, SUITE 100, FREDERICK 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Geneva G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

5

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 | 42621

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HOWARD ROBERT JOHNSTON

2. Date of Death Month / Day / Year: DECEMBER 22, 2001

3. Time of Death: 4:35 A M

4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 077-18-9771

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 3, 1923

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: FREDERICK

10c. City, Town or Location: MT. AIRY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6813 WOODVILLE ROAD

10f. Zip Code: 21771

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1942 - 1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): DAVID JOHNSTON

18. Mother's Name (First, Middle, Maiden Surname): FLORENCE VANIER

19a. Informent's Name/Reletionship (Type, Print): JOSEPHINE R. JOHNSTON/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6813 WOODVILLE RD, MT. AIRY, MD 21771

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HAGERSTOWN CREMATORY

Date: 12/23/01

20c. Location - City or Town, State: HAGERSTOWN, MARYLAND

21. Signature of Funeral Service Licensee: Rep P.B. MacKay

22. Name and Address of Facility: STAUFFER FUNERAL HOMES, P.A. 1621 OPOSSUMTOWN PIKE, FREDERICK, MD 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)

a. end stage dilated cardiomyopathy — ≈ 2 years

Due to (or as a consequence of):

b. with ejection fraction of 10-20%

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnency: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease, end stage renal failure on dialysis, pulmonary hypertension, hypothyroid, severe mitral regurgitation

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturet 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Ptace of tnjury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan B. Brinkley, MD

29c. License number: D0043389

29d. Date signed (Month, Day, Year): December 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan B. Brinkley, MD 198 Thomas Johnson Drive Suite 200 Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

7+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42622

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clara Helen Kirby
2. Date of Death Month Day Year: Dec. 27 2001
3. Time of Death: 9:35 A M
4a. Facility Name *(If not institution, give street and number)*: Clearview Nursing Home
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-6624
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 20, 1913
9. Birthplace *(State or Foreign Country)*: Hagerstown

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1037 Columbia Road
10f. Zip Code: 21742
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Launderer
16b. Kind of Business/Industry: Clothing

17. Father's Name *(First, Middle, Last)*: George Washington Armstrong
18. Mother's Name *(First, Middle, Maiden Surname)*: Cora Blanche Meyers

19a. Informant's Name/Relationship *(Type, Print)*: Francis J. Kronawetter / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1037 Columbia Rd., Hagerstown, MD 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removet from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Rose Hill Cemetery
Dete: 1/2/02
20c. Location - City or Town, Stete: Hagerstown, MD

21. Signeture of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac St., Hagerstown, MD 21740

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): Acute Bronchopneumonia — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as e consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnency 1☐ Live birth 2☐ Fetet deeth 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other *(specify)* 9☐ Unknown
23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease
Hypertension
Hyperlipidemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edson Moody
29c. License number: D07857
29d. Date signed *(Month, Day, Year)*: Dec. 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Edson B. Moody 1190 Mt. Aetna Road, Hagerstown, MD 21740

State Registrar

31. Date filed *(Month, Day, Yeer)*: DEC 28 2001
32. Registrar's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#14 perFHG803 1/16/02 EW

Certificate of Death

Reg. No. 2001 42623

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Manjula B. Kothari
2. Date of Death (Month, Day, Year): December 24, 2001
3. Time of Death: 0349 AM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 137-54-0815
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 9, 1943
9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 19106 Cherry Tree Drive
10f. Zip Code: 21742
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: ~~Other~~ Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Mohanlal Nanalal Chokshi
18. Mother's Neme (First, Middle, Maiden Surname): Kanchan Ben Shah

19a. Informant's Name/Relationship (Type, Print): Mitesh Kothari / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19218 Olde Waterford Road, Hagerstown, Md. 21742

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: December 25, 2001
20c. Location - City or Town, State: Smithsburg, Md.

21. Signeture of Funeral Service Licensee: ▶ Eric L. Brown
22. Name and Address of Facility: Rest Haven Funeral Home 1601 Pennsylvania Ave. Hagerstown, Md. 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert feilure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Coronary Artery Disease
Due to (or as a consequence of):
b. Diabetes
Due to (or as e consequence of):
Sequentially list conditions, If any, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Dyslipidemia
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Kidney Transplant

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medicel examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: ▶ Vasant A Kantawala MD
29c. License number: D0058362
29d. Date signed (Month, Day, Year): 12/26/1
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): 22911 Jefferson Blvd Smithsburg MD 21783

State Registrar

31. Date filed (Month, Day, Year): DEC 2 6 2001
32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42624

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virgie Crystal Kline

2. Date of Death Month Day Year: December 23, 2001

3. Time of Death: 2:05PM

4a. Facility Name (If not institution, give street and number): 10028 National Pike

4b. City, Town, or Location of Death: Big Pool

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-32-7359

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 23, 1913

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Big Pool

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 10028 National Pike

10f. Zip Code: 21711

10g. Citizen of What Country?: U,S,A

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th grade

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: residence

17. Father's Name (First, Middle, Last): Harry James Trumpower

18. Mother's Name (First, Middle, Maiden Surname): Cealie Elizabeth Reed

19a. Informant's Name/Relationship (Type, Print): Walter M. Kline spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10028 National Pike Big Pool, MD 21711

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkhead Cemetery

Date: Dec. 27, 2001

20c. Location - City or Town, State: Big Pool, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Donald Edwin Thompson Funeral Home, Inc 13607 National Pike Clear Spring, MD 21722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery disease

Due to (or as a consequence of):

c. Arteriosclerosis

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D23623

29d. Date signed (Month, Day, Year): December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] MD 11110 Medical Campus Rd Hagerstown Md 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42625

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Austin S. Kelly	December 26, 2001	8:55 A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
College View Nursing Home	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-18-0924	1☒M 2☐F	79 Yrs.			Sept. 6, 1922	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
717 Fairview Avenue	21701	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		miller and grain analyst	own feed mill company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Raymond L. Kelly	Belva Grace Wiles

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
A. Genevieve Kelly / wife	717 Fairview Ave., Frederick, MD 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Olivet Cemetery	12/28/01	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jacqueline Kreb	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SENILE DEMENTIA	2 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- HTN
- DECUB. ULCERS,
- ASPIRATION PNEUMONIA

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D 31912	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIO HERMOSO, MD - 1514 OPOSSUMTOWN PIKE. FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42626

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Winthrop Dale Lodge
2. Date of Death (Month, Day, Year): Dec 26, 2001
3. Time of Death: 7:30p M
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata Md
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 216-30-4696
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 28, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: White Plains
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3982 Hanson Road
10f. Zip Code: 20695
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Latent Finger Print Expert
18b. Kind of Business/Industry: FBI/Law Enforcement

17. Father's Name (First, Middle, Last): Sidney Johnson Lodge
18. Mother's Name (First, Middle, Maiden Surname): Edna VanCamp

19a. Informant's Name/Relationship (Type, Print): Dreama S. Lodge - Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4160 Bluebird Drive, Waldorf, MD 20603

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Huntt Crematory
Date: 12-28-01
20c. Location - City or Town, State: Waldorf, MD 20601

21. Signature of Funeral Service Licensee: John P. Knisley M01164
22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septicemia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Respiratory Insufficiency

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael A Leatherwood
29c. License number: D-21031
29d. Date signed (Month, Day, Year): 12/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Leatherwood A,MD102070 Old lineCenter,Waldorf,MD20602

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Winthrop Dale Lodge

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 42627

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RALPH EUGENE LITTLE SR
2. Date of Death — Month: DECEMBER Day: 17 Year: 2001
3. Time of Death: 10:00 P.M.
4a. Facility Name *(If not institution, give street and number)*: MARINER HEALTH OF FOREST HILL
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 220-18-3939
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 9 1925
9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 147 Maulsby Avenue
10f. Zip Code: 21014
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: minister
16b. Kind of Business/Industry: Independent Bible Church

17. Father's Name *(First, Middle, Last)*: Lewis B. Little
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen C. Hahn

19a. Informant's Name/Relationship *(Type, Print)*: Estella J. Little (spouse)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 147 Maulsby Ave., Bel Air, Md 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Evergreen Memorial — Date: 12-20-01
20c. Location - City or Town, State: Finksburg, Md

21. Signature of Funeral Service Licensee: Brian L. Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Progressive dementia
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
hypertension
hx cerebral vascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn
29c. License number: D32295
29d. Date signed *(Month, Day, Year)*: December 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN C.S.W. MacPhail / Bel Air, MD 21014

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

WJ 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42628

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard William Legore
2. Date of Death: Month Dec. Day 18 Year 2001
3. Time of Death: 11:45 PM
4a. Facility Name (If not institution, give street and number): 2222 Sams Creek Road
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-32-2454
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 3 1923
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2222 Sams Creek Road
10f. Zip Code: 21157
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bteck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Black & Decker Inc.

17. Father's Name (First, Middle, Last): Lester Howard Legore
18. Mother's Name (First, Middle, Maiden Surname): Pauline Newcomer

19a. Informant's Name/Relationship (Type, Print): Elsie Legore Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2222 Sams Creek Road Westminster, MD 21157

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Evergreen Mem. Park
Date: December 22, 2001
20c. Location - City or Town, Stete: Finksburg, Maryland

21. Signature of Funeral Service Licensee: James B Corry
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC PROSTATE CA — 5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D25398
29d. Date signed (Month, Dey, Year): 12-20-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Flavio Cruter 555 South Center St Westminster, Md 21157

State Registrar

31. Date filed (Month, Day, Year): DEC 20 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15+IVA WJR

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42629

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Beatrice	Lillian	Roemer	December 16 2001	11:01 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Hospital	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-12-7479	1☐M 2☒F	78 Yrs.			January 29, 1923	Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Harford	Joppa	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
811 Old Joppa Road	21085	USA

11. Marital Statua	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	Cottege (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
John Stanley	Anna Walters

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Richard Roemer Son	9411 Kilbride Court, Perry Hall, Md. 21128

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Highview Mem'l Garden	12/19/2001	Fallston, Md.

21. Signature of Funeral Service Licensee	22. Name and Addresa of Facility
▶ Carol Blumberg	Schimunek Funeral Homes 9705 Belair Road, Baltimore, Md. 21236

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)	a. UROSEPSIS	two DAYS
Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or aa a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yea, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yea 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yea 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0056607	December 16th 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Angelo 2112 BelAIR RD. #1 FALLSTON MD. 21047

10

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 18 2001	Penne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 28e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42630

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Donald E Leavitt	December 14, 2001	1928 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
575-58-8530	1 XX M 2 ☐ F	49 Yrs.			June 13, 1952	Rhode Island

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Edgewood	1 ☐ Yes XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2215 Rosewood Drive	21040	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married XX 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes XX 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes XX 2 ☐ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1 Year	Carpenter	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Calvin Leavitt	Ruth Tucker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Teresa A. Leavitt/Wife	2215 Rosewood Drive Edgewood, Maryland 21040

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 XX Other (Specify) Entombment	Bel Air Memorial Gdns.	12/17/01	Bel Air, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Amanda David	Schimunek Funeral Home, Inc. 610 W. Macphail Road Bel Air, Maryland 21014

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage Liver Disease	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Hepatitis C	4 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ D M M	AU4176435 M13662	December 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID M MORRIS, MD. 22 South Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 18 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42631

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
EMMA SUSAN MARTIN	December 29, 2001	11:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WASHINGTON COUNTY HOSPITAL	HAGERSTOWN	WASHINGTON

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☒F	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-60-4484		82 Yrs.			JAN. 18, 1919	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WASHINGTON	HAGERSTOWN	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9807 MEADOW ROCK DRIVE	21740	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN WESLEY AMBROSE	EMMA ELIZABETH MULLENIX

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
EARL T. MARTIN, HUSBAND	9807 MEADOW ROCK DRIVE, HAGERSTOWN, MARYLAND 21740

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	ROSE HILL CEMETERY	JAN. 2, 2002	HAGERSTOWN, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kelly A. Zimmerman	BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hepatic Encephalopathy	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Micronodular cirrhosis Due to (or as a consequence of):	5 years
	c. Due to (or as a consequence of):	
	d.	

If FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease S/P CABG 1993

S/P Aortic valve replacement 1993

Thrombocytopenia 2° splenic sequestration

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
David M Brown MD	D0057600	12/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Brown 22911 Jefferson Blvd. Smithsburg, md 21783

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 3 1 2001	Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Martin, Emma

DHMH 17 Rev 1/2001

ORIGINAL

01-7347-043
mnmr
Robert A. Moore

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42632

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Allen Moore
2. Date of Death (Month, Day, Year): December 28, 2001
3. Time of Death: 1809 pm
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-13-4579
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 16 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 27, 1985
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Clear Spring,
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12312 Big Spring Road
10f. Zip Code: 21722
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: High School

17. Father's Name (First, Middle, Last): Douglas E. Moore
18. Mother's Name (First, Middle, Maiden Surname): Cindy R. Bowman

19a. Informant's Name/Relationship (Type, Print): Douglas E. Moore
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12312 Big Spring Rd. Clear Spring, MD 21722

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Shanktown Cem. | Date: January 2, 2002
20c. Location - City or Town, State: Big Pool, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Donald Edwin Thompson Funeral Home, Inc 13607 National Pike Clear Spring, MD 21722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 12-28-01
28b. Time of Injury: 1700 P M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: WITH A VEHICLE DRIVER OF VEHICLE IN COLLISION
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY
28f. Location (Street and Number or Rural Route Number, City or Town, State): RT40E ASHTON RD WASHINGTON, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANNE A. KOPACH, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 42633

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): PAUL B MILLER

2. Date of Death (Month, Day, Year): December 23, 2001

3. Time of Death: 11:00 PM

4a. Facility Name (If not institution, give street and number): Garrett County Memorial Hospital

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 173-03-2981

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Jan 16, 1918

9. Birthplace (State or Foreign Country): Waynesboro, PA

Usual Residence of Decedent

10a. Stete: MD

10b. County: Garrett

10c. City, Town or Location: Oakland

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: Cherry Hill Assisted Living (Box 437)

10f. Zip Code: 21550

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Collega (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chiropractor

16b. Kind of Business/Industry: Own

17. Father's Name (First, Middle, Last): Joseph Daniel Miller

18. Mother's Name (First, Middle, Maiden Surname): Ida Bumbaugh

19a. Informant's Name/Relationship (Type, Print): P. Daniel Miller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 186 Thornberry RD Oakland MD 21550

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Burns Hill Cemetery

Data: Dec 28

20c. Location - City or Town, State: Waynesboro PA 17268

21. Signature of Funeral Service Licensee: James A. Bowersox

James A. Bowersox

22. Name and Address of Facility: Grove-Bowersox Funeral Home, Inc.

50 S Broad Street Waynesboro PA 17268

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. atherosclerotic cardiovascular disease — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Alzheimers Type

Diabetes Mellitus Type Two

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Walter K Naumann M.D.

29c. License number: D0025759

29d. Date signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WALTER K NAUMANN

PO Box 247, 106 Cemetery Road, Accident MD 21520

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42634

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Silence Margaret Michelet

2. Date of Death (Month, Day, Year): December 23, 2001

3. Time of Death: 1:25 P.M

4a. Facility Name (If not institution, give street and number): Ashbury Methodist Village

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-42-2245

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 8, 1910

9. Birthplace (State or Foreign Country): Nebraska

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 333 Russell Ave.

10f. Zip Code: 20877

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Lloyd Bennett Wilson

18. Mother's Name (First, Middle, Maiden Surname): Silence Stewart

19a. Informant's Name/Relationship (Type, Print): Robert W. Michelet (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Church Circle, P.M.B 176 Annapolis, Md. 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Entombment 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory

Date: Dec. 24, 2001

20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis R. Davis

22. Name and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 3 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Sick sinus syndrome

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Assisted living

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Robert Birschbach MD

29c. License number: D04115

29d. Date signed (Month, Day, Year): December 23, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): H. Robert BIRSCHBACH, MD, 201 Russell Avenue Gaithersburg Md. 20877

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No 2001 42635

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Jesse James MURRAY	December 22 2001	0355 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-12-7531	1☒M 2☐F	87 Yrs.			March 16,1914	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Smithsburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
22516 Cave Hill Road	21783	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4	0	farmer	farming

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Washington Grant Murray	Bessie B. Bowers

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William G. Murray - son	1039 Security Road, Hagerstown, Md. 21742

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Lawn Memorial Pk.	12/27/01	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Scott M Minnich	MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. cardiac Vascular Accident	3 wks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Prostate

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D18019	DEC 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VASANT DATTA, MD 340 MILL ST HAGERSTOWN MD 21740

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 2 6 2001	Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Jesse James Murray 12-22-01

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42636

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): May Lillian MULLENIX
2. Date of Death (Month, Day, Year): December 19, 2001
3. Time of Death: 6.30 pm.

4a. Facility Name (If not institution, give street and number): 11 West Baltimore St., Apt. 123
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-4750
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 7, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11 West Baltimore St., Apt. 123
10f. Zip Code: 21740
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: her own

17. Father's Name (First, Middle, Last): John H. Barnhart
18. Mother's Name (First, Middle, Maiden Surname): Ruby Frasier

19a. Informant's Name/Relationship (Type, Print): Dorothy M. Tritapoe - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1638 Rohrersville Rd., Knoxville, Md. 21758

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery | Date: 12/24/01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — MINS.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D283 65
29d. Date signed (Month, Day, Year): 12-20-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANZAR. JSHAFI 368 MILL HAGERSTOWN MD 21740.

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42637

Molloy, Francis, Xavier

D.O.B. March 07, 1922

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Xavier Molloy
2. Date of Death (Month, Day, Year): December 22 01
3. Time of Death: 505
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 164-18-7490
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 7, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 913 Beechwood Drive
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Pangborn Corp.

17. Father's Name (First, Middle, Last): Francis Xavier Molloy Sr.
18. Mother's Name (First, Middle, Maiden Surname): Katharine Helene Doyle

19a. Informant's Name/Relationship (Type, Print): Dennis Molloy / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 913 Beechwood Drive, Hagerstown, Md. 21742

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery | Date: December 27, 2001
20c. Location - City or Town, State: Hagerstown, Md.

21. Signature of Funeral Service Licensee: Eric L. Brown Eric L. Brown
22. Name and Address of Facility: Rest Haven Funeral Home, 1601 Pennsylvania Ave. Hagerstown, Md. 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	PERITONITIS	4 W
Due to (or as a consequence of): b.	END STAGE RENAL FAILURE	10Y
Due to (or es e consequence of): c.	CONGESTIVE HEART FAILURE	10Y
Due to (or es e consequence of): d.	STROKE	5Y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
ANEMIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D52323
29d. Date signed (Month, Day, Year): 12/22/4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Khalid M. Waseem 19414 Leitersburg Pike, Hagerstown, Md. 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: Jennie B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42638

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel Genieva Moats

2. Date of Death (Month, Day, Year): December 19 2001

3. Time of Death: 1730 M

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-1001

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 14, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11 West Baltimore Street

10f. Zip Code: 21740

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): bookkeeper

18b. Kind of Business/Industry: manufacturing

17. Father's Name (First, Middle, Last): Milton Earl Moats

18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Byers

19a. Informant's Name/Relationship (Type, Print): Henrietta Potter/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16505 virginia Avenue, Cottage 55, Williamsport, MD 21795

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery

Date: 12/22/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in deeth)

a. Adenocarcinoma of the stomach with widespread metastases — 6 months

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnent in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier ▶ Robert Brull MD Personal Physician

29c. License number: D04359

29d. Date signed (Month, Day, Year): Dec 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Brull 1459 Potomac Ave. Hagerstown, Md 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 2 6 2001

32. Registrar's Signature ▶ Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42639

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean D. Metcalf
2. Date of Death: Month: December Day: 22 Year: 2001
3. Time of Death: 1805
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 186-28-3876
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 65 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): 09/16/1936
9. Birthplace (State or Foreign Country): PA

Usual Residance of Decedant

10a. State: PA
10b. County: Franklin
10c. City, Town or Location: Greencastle
10d. Inside City Limits: 1☑ Yas 2☐ No
10e. Street and Number: 365 Wayburn Street
10f. Zip Coda: 17225
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☑ Married 3☐ Widowad 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☑ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☑ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completad): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Homemaker
16b. Kind of Businass/Industry: Own home

17. Fathar's Nama (First, Middla, Last): Cleneth B. LaMaster, Sr.
18. Mothar's Nama (First, Middla, Maiden Surnama): Mabel I. Tritle

19a. Informant's Name/Ralationship (Type, Print): Marsha K. Myers/Daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 10077 Church Hill Road Mercersburg, PA 17236

20a. Method of Disposition: 1☑ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Nama of cametary, crematory or othar placa): Spring Grove Cemetery
Data: Dec. 27 2001
20c. Location - City or Town, Stata: Lemasters, PA

21. Signatura of Funaral Service Licensaa: Calvin T. Fries
22. Nama and Addrass of Facility: Lininger-Fries Funeral Home Inc. 47 N. Park Ave., Mercersburg, PA

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory errest, shock, or haart tailura. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in deeth)
a. pneumonia — 0DAYS
Dua to (or as a consequanca of):
b. chronic lung disease
Dua to (or as a consequance of):
c. pulmonary arrest
Dua to (or as a consequanca of):
d.

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that Initiated evants rasulting in daath) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.
acute psychosis, extrapyramidal symptoms, malnourishment, polycystic renal disease and chronic kidney encephalopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☑ No
26. Placa of Daath (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidanca 8☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and placa, end due to the causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, dete and placa, end due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: James - Shift Supervisor
29c. Licensa number: D5043
29d. Date signed (Month, Day, Yaar): 12/24/01

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): Dr. Campo 1150 Professional Ct, Hag. Md. 21740

State Registrar

31. Date filed (Month, Day, Yaar): DEC 2 6 2001
32. Registrar's Signatura: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funaral director, page 2 should be datached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Jean Dolores Metcalf

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 42640

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
THOMAS WESLEY MILLAR	December 30 2001	1:10A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Memorial Hospital	Prince Frederick	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-20-5012	1 X M 2 F	85 Yrs.			September 8,1916	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Bethesda	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4632 River Road	20816-3032	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Master Sgt.	USAF

17. Father's Name (First, Middle, Last)	16. Mother's Name (First, Middle, Maiden Surname)
Charles Wallace Millar	Edna Louise Simmons Millar

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Lillian Walker/Sister	4632 River Rd. Bethesda,MD 20816-3032

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Old Durham Cemetery	1/2/02	Ironsides,Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
David C. Ehl M00945	AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiovascular Accident	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b. Due to (or es e consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetel death 3 Ectopic pregnency 4 Pregnant et time of deeth 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Renal Insufficiency
Hypernatremia
Mass Right upper lobe

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1 Yes 2 No 3 Probably 4 Unknown	1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	26a. Dete of Injury (Month, Day Year)	26b. Time of Injury M	26c. Injury et Work?	26d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined			1 Yes 2 No	
	26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			26f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and *manner* as stated.
2 **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
	D25435	12/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mukesh Mathur,M.D. 110 Hospital Dr. suite 305 Prince Frederick,MD 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 31 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42641

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Benedetta Josephine Musotto
2. Date of Death (Month, Day, Year): December 21, 2001
3. Time of Death: 0500

4a. Facility Name (If not institution, give street and number): Golden Crest Assisted Living
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-36-0125
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 18 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 811 Fairfield Ave.
10f. Zip Code: 21157
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Hecht Company Department Store

17. Father's Name (First, Middle, Last): Andrew Lombardo
18. Mother's Name (First, Middle, Maiden Surname): Rose Dantoni

19a. Informant's Name/Relationship (Type, Print): Frances Conigliaro (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 485 Pleasanton Rd. #13 Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery
Date: 12 - 27 2001
20c. Location - City or Town, State: Baltimore City, MD

21. Signature of Funeral Service Licensee: John K. Pritts
22. Name and Address of Facility: Pritts Funeral Home and Chapel, P.A. 412 Washington Rd. Westminster, Maryland 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Abdominal Infection	1wk
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	ASCVD	25yr
Due to (or as a consequence of):		
c.	Advanced age	90
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) assisted living

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Middleton MD
29c. License number: D25443
29d. Date signed (Month, Day, Year): 12/21/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton MD 688 Poole Rd, Westminster, Md 21157

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42642

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John W. MacGowan
2. Date of Death — Month: December; Day: 14; Year: 2001
3. Time of Death: 1:32 am
4a. Facility Name (If not institution, give street and number): Gilchrist Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-34-8681
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/14/1938
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: BelAir
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1504 Charter Oak Avenue
10f. Zip Code: 21014
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1955-59
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management Supervisor Information
16b. Kind of Business/Industry: government City of Baltimore
17. Father's Name (First, Middle, Last): John Milton Dandy
18. Mother's Name (First, Middle, Maiden Surname): Jane Leiter Cowan Dandy
19a. Informant's Name/Relationship (Type, Print): Mrs. Anna Lee MacGowan (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1504 Charter Oak Avenue Bel Air, Maryland 21014
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory — Date: 12/15/01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Mark T. [illegible]
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road BelAir, Md. 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Non-Hodgkin's Lymphoma — Due to (or as a consequence of): — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD
29c. License number: 025205
29d. Date signed (Month, Day, Year): December 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 18 2001
32. Registrar's Signature: ▶ Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42643

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GRACE R. MOORE
2. Date of Death Month Day Year: December 26, 2001
3. Time of Death: 0015 M
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 515-05-9605
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 21, 1909
9. Birthplace *(State or Foreign Country)*: MISSOURI

Usual Residence of Decedent

10a. State: MD
10b. County: CAROLINE
10c. City, Town or Location: DENTON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 410 COLONIAL DRIVE
10f. Zip Code: 21629
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: CHARLES CHENEY
18. Mother's Name *(First, Middle, Maiden Surname)*: MYRTLE MAY CRANE

19a. Informant's Name/Relationship *(Type, Print)*: DONNA J. NIELSEN/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 410 COLONIAL DR., DENTON, MD 21629

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WILLIS CHAPEL CEMETERY
Date: 12-30-01
20c. Location - City or Town, State: RAPPAHANOCK, VA

21. Signature of Funeral Service Licensee: JOHN R. MERCERON CFS
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic heart disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: MD
29c. License number: D0056659
29d. Date signed *(Month, Day, Year)*: 12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. AFZAL M.D. 300 AURORA ST CAMBRIDGE, MD 21613

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001
32. Registrar's Signature: Penny G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Grace Moore

SBB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42644

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month Day Yaar	3. Time of Daath
Kathryn	Masaitis	December 25, 2001	12:04 PM

4a. Facility Name (If not institution, giva straat and number)	4b. City, Town, or Location of Death	4c. County of Daath
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Sacurity Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplace (Stata or Foraign Country)
184-10-9310	1☐M 2☒F	83 Yrs.			Oct. 6, 1918	Pennsylvania

Usual Rasidance of Decadant

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Frederick	Frederick	1☒Yas 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
2102 Whitehall Road, Unit BA	21702	U.S.A.

11. Marital Status	12. Was Dacadant Evar in U.S. Armad Forces?	13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Rece - Amarican Indian, Black, Whita, atc.
1☐Navar Married 2☒Marriad 3☐Widowed 4☐Divorced	1☐Yas 2☒No If Yas, Give Yaar or Datas:	1☐Yas 2☒No Specify:	Specify: White

15. Decadent's Education (Specify only highast grada complatad)		16a. Decadent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratirad)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Homemaker	Own Home

17. Fathar's Nama (First, Middla, Last)		18. Mother's Nama (First, Middla, Maidan Sumame)	
Michael	Yasenchak	Mary	Figlar

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)
Stiney A. Masaitis, Husband	2102 Whitehall Rd., Unit BA, Frederick, Md. 21702

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of cematary, cramatory or othar placa)	Date	20c. Location - City or Town, Stata
1☒Burial 2☐Cramation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	St. Johns Cemetery,	Dec. 29, 2001	Frederick, Maryland

21. Signature of Funaral Servica Licensee: ▶ Richard E. Sard MO0255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home, 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on each lina.

		Approximate Intarval Batwaan Onset and Death
Immediata Cause (Final disease or condition resulting in daath)	a. Anoxic Encephalopathy	2 days
Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaasa or injury that initiated events rasulting in daath) Last	b. Due to (or as a consaquance of): Cardiac Arrest	2 days
	c. Due to (or as a consaquance of): Atherosclerotic Cardiovascular Disease	years
	d. Due to (or as a consaquanca of):	

IF FEMALE:
23b. Was decadant pregnant in the past 12 months? 1☐Yas 2☒No 9☐Unknown

23c. If yas, outcoma of pregnancy: 1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Othar (specify) 9☐Unknown

23d. Data of delivery: Month Day Year

Part II. Other significant conditions contributing to daath but not rasulting in tha undarlying causa givan in Part I.

Alzheimers disease
Parkinsonian Syndrome

23e. Did tobacco usa contribute to tha causa of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performad? 1☐Yas 2☒No

24b. Were autopsy findings available prior to complation of causa of daath? 1☐Yas 2☐No

25. Was case referred to madical examiner? 1☐Yes 2☒No

26. Placa of Daath (Check only ona)
Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA
Othar: 4☐Nursing Homa 5☐Residanca 6☐Othar (Specify)

27. Manar of Daath: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date and placa, and due to the cause(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurrad at the time, date and place, and due to tha cause(s) and mannar statad.

29b. Signature and titla of cartifiar: ▶ [signature]

29c. Licensa numbar: D26516

29d. Date signad (Month, Day, Yaar): DEC 28 2001

30. Nama and address of parson who complatad causa of daath (Item 23a) (Typa, Print)
Allen J. Gibson MD 1475 TANEY AVE FRED MD 21702

State Registrar

31. Data filed (Month, Day, Yaar): DEC 28 2001

32. Registrar's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 17 Rav 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 | 12615

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rufus Earl Malone

2. Date of Death (Month, Day, Year): December 25, 2001

3. Time of Death: 6:30 AM

4a. Facility Name (If not institution, give street and number): Homewood at Crumland Farms

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 465-20-5838

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 23, 1926

9. Birthplace (State or Foreign Country): Arkansas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes XX ☐ No

10e. Street and Number: 7404 Willow Road

10f. Zip Code: 21702

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1957-1977

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Military

16b. Kind of Business/Industry: US Army

17. Father's Name (First, Middle, Last): Ebb Malone

18. Mother's Name (First, Middle, Maiden Surname): Rose Unknown

19a. Informant's Name/Relationship (Type, Print): Mrs. Frances Klinedinst, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6124 Quinn Orchard Rd., Frederick, Md. 21704

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory; Date: Dec. 26, 2001

20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: ▶ Richard E. Shaf M00255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervet Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anemia — Approximate Intervet Between Onset and Death: 2 Month

Due to (or es e consequence of):

b. CVA & Paralysis

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

c. Diabetes Mellitis

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of deeth 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Martha J Pierce, MD

29c. License number: D46248

29d. Date signed (Month, Day, Year): December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha Pierce, M.D., 300 West Ninth St., Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42646

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Hiram Thomas Miller Jr.	December 24 2001	3:32 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
224-20-2591	1☒M 2☐F	78 Yrs.			June 5, 1923	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Walkersville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
300 Chapel Court, Unit 103	21793	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Electrician	Union

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Hiram Thomas Miller, Sr.	Martha Taylor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Katherine V. Miller / Wife	300 Chapel Court, Unit 103 Walkersville, Maryland 21793

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hagerstown Crematory	December 28, 2001	Hagerstown, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Stauffer Funeral Homes, P.A. 40 Fulton Avenue Walkersville, Maryland 21793

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arrest	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b. CAD	
	Due to (or as a consequence of):	
	c. HTN	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ESRD on peritoneal dialysis, S/P CVA, S/P PTCA, Anemia, Arrhythmias

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D0057837	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nashit Hashmi 172 Thomas Johnson Dr Ste 202, Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
~~12/26/01~~ DEC 27 2001	[signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 42647
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MARGARET VIRGINIA MORAN	DECEMBER 21, 2001	8:45 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-18-7820	1☐M 2☒F	78 Yrs.					May 2, 1923	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Braddock Heights	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6612 Jefferson Blvd.	21714	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Administration	Life Insurance Comp.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roy Cletus Creager	Catherine Virginia Herman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Moran, husband	PO Box 68 Braddock Heights, Maryland 21714

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Olivet Cemetery	12/27/2001	Frederick, Maryland

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
▶ Ryan M. Bagan	M00999	Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	Days-Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. perforated colon	weeks
	Due to (or as a consequence of): c. probable colonic abscess	weeks
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D26499	12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Muller, M.D. 4 Culwell Drive Mt. Airy MD 21771

12

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Penny G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42648

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FREDERICK CARROLL MURPHY
2. Date of Death: Month 12 Day 09 Year 2001
3. Time of Death: 4:40 PM
4a. Facility Name *(If not institution, give street and number)*: 3750 SUNNYSIDE ROAD
4b. City, Town, or Location of Death: EAST NEW MARKET
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 220-28-0541
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09/27/1933
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: DORCHESTER
10c. City, Town or Location: EAST NEW MARKET
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3750 SUNNYSIDE ROAD
10f. Zip Code: 21631
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: POLICE OFFICER
16b. Kind of Business/Industry: LAW ENFORCEMENT

17. Father's Name *(First, Middle, Last)*: FREDERICK MURPHY
18. Mother's Name *(First, Middle, Maiden Surname)*: ELEANOR WINDSOR

19a. Informant's Name/Relationship *(Type, Print)*: PHYLLIS MURPHY / WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3750 SUNNYSIDE ROAD EAST NEW MARKET, MD 21631

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR. — Date: 12/11/01
20c. Location - City or Town, State: STEVENSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Thomas K. Helfenbein
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MARYLAND 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. End Stage Prostate Cancer, widely metastatic — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: H 42587
29d. Date signed *(Month, Day, Year)*: 12/10/2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. RUSSELL SHILLING 555 CYNWOOD DRIVE EASTON, MARYLAND 21601

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 11 2001
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Amend Item 10a per F.D. 12/20/2001 Carroll County, wjl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42649

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Lottie Noble	DECEMBER 20th 2001	6:05 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Northwest Hospital	Baltimore, Maryland	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-24-8053	1☐ M 2☒ F	92 Yrs.			March 27 1909	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
N. Carolina ~~Maryland~~	Lenoir	Deep Run	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
832 Blaney Blizzard Road	28525	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th grade		Homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ira Jones Grady	Nettie Elizabeth Thompson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Helen Lages daughter	3626 Langrehr Road Baltimore, MD 21244

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Dete	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	Westview Cemetery	December 27 2001	Kinston, North Carolina

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶X James B Causey	Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	DAYS.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequenca of): b. URINARY TRACT INFECTION	DAYS
	Due to (or es e consequence of): c.	
	Due to (or es e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION, CARDIOMYOPATHY, ATRIAL FIBRILLATION, HYPOTHYROIDISM, GASTROESOPHAGEAL REFLUX DISEASE, DEMENTIA,

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner es steted.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ R. Ranganagow MD	D54288	December 20th 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R RANGANATHAN. Northwest Hospital Medical Center 5401 Old Court Rd Randallstown MD 21133

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 6

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42650

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
WILLIAM CHANDLER NILES	DEC 09, 2001	15:35 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ER UPPER CHESAPEAKE MED CTR	BEL AIR	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-30-2114	1☒M 2☐F	67 Yrs.			Dec. 23, 1933	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Bel Air	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1000 Shelburne Road	21015	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Weapons Testing	U.S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lorin A. Niles	Marie Elbert Beimschla

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan R. Niles - Wife	1000 Shelburne Road, Bel Air, Maryland 21015

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify)	Hilltop Service Corp.	12/14/01	Towson, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility McComas Funeral Home, P.A. 50 West Broadway, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASCVD	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] DME	OCME	DEC 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GSPRABHU MD 728 BEL AIR MD #134 BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 12 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-7272-043
B.K.S
WILLIAM E. NEEDHAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 42651

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM EDWARD NEEDHAM
2. Date of Death (Month, Day, Year): DEC. 21, 2001
3. Time of Death: 1355 PM
4a. Facility Name *(If not institution, give street and number)*: WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 215-50-8086
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 48 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: Sept. 29, 1953
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 39 Hump Road
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner & Operator
16b. Kind of Business/Industry: Polish & Shine Co.

17. Father's Name *(First, Middle, Last)*: James Needham
18. Mother's Name *(First, Middle, Maiden Surname)*: Doretta Ahrens

19a. Informant's Name/Relationship *(Type, Print)*: Pamela L. Needham (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 39 Hump Road, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lutheran Cemetery
Date: 12/27/01
20c. Location - City or Town, State: Creagerstown, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MARYLAND 21788

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CHEST INJURIES
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 12/21/01
28b. Time of Injury: 12:44P M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Driver involved in auto accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Mount Hanlock, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. M. [illegible]
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: DEC. 23, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001
32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42652

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAURICE WILLIAM NOCK
2. Date of Death (Month, Day, Year): December 17, 2001
3. Time of Death: 9:58 PM
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 220-32-2426
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 3, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 809 Little John Drive
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: AirForce
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Broker
18b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Matthew Avery Nock
18. Mother's Name (First, Middle, Maiden Surname): Agnes Leonard

19a. Informant's Name/Relationship (Type, Print): Shirley B. Nock/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 809 Little John Dr., Salisbury, MD 21804

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Jerusalem Cemetery
Date: 12/22/01
20c. Location - City or Town, State: Parsonsburg, MD

21. Signature of Funeral Service Licensee: [signature] L. Holloway
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Pneumonia — 2 WEEKS
Due to (or as a consequence of):
c. Multiple Myeloma — 1 YEAR
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other **significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: P147066
29d. Date signed (Month, Day, Year): December 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN ABEL, M.D. University of Maryland Medical System 22 South Greene Street Baltimore, MD 21210

State Registrar

31. Date filed (Month, Day, Year): DEC 20 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42653

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Richard PRYOR

2. Data of Death Month Day Yaar: Dec. 18, 2001

3. Time of Death: 1355

4a Facility Name (If not institution, giva street and number): 19839 Scott Hill Drive

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-12-2750

6. Sax: 1☒M 2☐F

7. Aga (In yrs. last birthday): 91 Yrs. If Under 1 Year: Months Days; If Under 24 Hrs.: Hours Min.

8. Data of Birth (Month, Day, Year): Nov. 9, 1910

9. Birthplaca (State or Foreign Country): Maryland

Usual Rasidence of Decedant

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 19839 Scott Hill Drive

10f. Zip Coda: 21742

10g. Citizan of What Country?: USA

11. Marital Status: 1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yas, Giva Yaar or Datas: 1942-1946

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:

14. Raca - American Indian, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highast grada completed): Elamentary/Secondary (0-12): 12; Collaga (1-4or 5+): 0

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratirad): window clerk

16b. Kind of Business/Industry: postal services

17. Fathar's Name (First, Middle, Last): James Walter Pryor

18. Mothar's Name (First, Middle, Maiden Surnama): Olive Idella Wolfe

19a. Informant's Name/Ralationship (Type, Print): Ruth M. Pryor wife

19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 19839 Scott Hill Dr., Hagerstown, Md. 21740

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Rose Hill Cemetery

Data: 12/21/01

20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signature of Funaral Sarvica Licensee: Scott Mennill

22. Nama and Addrass of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximate Intarval Between Onsat and Daath

Immediate Ceuse (Finel disaese or condition resulting in death): a. Carcinoma of pancreas — 3 months

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiated evants rasulting in death) Last:

b. Dua to (or es e consequenca of):

c. Dua to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No

24b. Wara autopsy findings available prior to comptation of causa of daath? 1☐Yas 2☐No

25. Was casa rafarrad to medical axaminar? 1☐Yas 2☑No

26. Placa of Death (Check only one): Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA; Other: 4☐Nursing Home 5☐Residance 6☐Other (Specify)

27. Mannar of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding invastigation 6☐Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☐**Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and due to the causa(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and ptaca, and dua to the causa(s) and mannar stated.

29b. Signature and title of certifier: Frederick Chan MD

29c. Licansa number: D23623

29d. Data signad (Month, Day, Year): December 19, 2001

30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print): Lt Kass III MD 11110 Medical Campus Rd Hagerstown Md

State Registrar

31. Data filed (Month, Day, Year): DEC 20 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42654

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
William	Earl	PETEFISH	December 18, 2001	2:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
17455 General Lee Drive.	Sharpsburg	WASHINGTON

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
722-05-3028	1 ☒ M 2 ☐ F	72 Yrs.			Dec. 25, 1928	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington	Sharpsburg	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
17455 General Lee Drive	21782	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9	0	Track Supervisor	Railroad

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
Alfred	M.	Petefish	Pauline	Mabel	Duncan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lorraine M. Petefish	17455 General Lee Drive. Sharpsburg, MD 21782

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mt. View Cemetery	Dec. 21, 2001	Sharpsburg, MD 21782

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	OSBORNE FUNERAL HOME P.O.Box# 348 Williamsport, MD 21795

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure Cerebrovascular Accident

Diabetes Mellitus

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: ☒ 1 Natural; 2 ☐ Accident; 3 ☐ Suicide; 4 ☐ Homicide; 5 ☐ Pending investigation; 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William J Hammersh Jr	D 0055926	12/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William J Hammersh Jr 29 Wyand Dr Keedysville MD 21756

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 2 0 2001	▶ Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42655

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Marion Pippen, Jr.

2. Date of Death (Month, Day, Year): December 14, 2001

3. Time of Death: 7:29 A M

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: ———

Funeral Director

5. Social Security Number: 219-38-1531

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1942

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2912 Trellis Lane

10f. Zip Code: 21009

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman

16b. Kind of Business/Industry: Distillery

17. Father's Name (First, Middle, Last): Albert Marion Pippen, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Cornelia Ruby Smith

19a. Informant's Name/Relationship (Type, Print): Mark Andrew Pippen/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2912 Trellis Lane, Abingdon, MD 21009

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.

Date: 12-17-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Subdural hematoma and

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Subarachnoid hemorrhage

Due to (or as a consequence of):

c. Head Injuries

Due to (or as a consequence of):

d.

J Pertaum MD

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chest injuries with left hemothorax

Huntington's Disease

Hypertensive Arteriosclerotic Cardiovascular Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): 12/2/01

28b. Time of Injury: 5:00PM

28c. Injury at Work? 1☐Yes 2☑No

28d. Describe how injury occurred: Subject jumped From Height

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4403 Flintville Rd, Harford County, Maryland

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: P 15914

29d. Date signed (Month, Day, Year): December 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theresa M. Mentzer 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 18 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42656

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
GREGG REMINGTON POTVIN	12 / 06 / 2001	5:37 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SPA CREEK	ANNAPOLIS	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
518-20-5888	1[X] M 2[ ] F	76 Yrs.			07/20/1925	WASHINGTON

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	QUEEN ANNES	STEVENSVILLE	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
300 BAY VIEW DRIVE	21666	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Yeer or Detes WW II	1[ ] Yes 2[X] No Specify:	Specify WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	5+	ATTORNEY	LAW

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
FRANK POTVIN	LORA REMINGTON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOHN POTVIN	3805 THOMAS PT. ROAD ANNAPOLIS, MD 21403

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1[ ] Burial 2[X] Cremetion 3[ ] Removal from State 4[ ] Donetion 5[ ] Other (Specify)	CHESAPEAKE CREMATION	12/8/2001	STEVENSVILLE, MD

21. Signeture of Funeral Service Licensee: Thomas K. Helfenbein

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK RD. CHESTER, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in deeth): a. Bladder Cancer — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or es e consequence of):

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnency	23d. Dete of delivery Month / Dey / Year
1[ ] Yes 2[/] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetel death 3[ ] Ectopic pregnancy 4[ ] Pregnent at time ot deeth 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[/] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[/] No	1[ ] Yes 2[/] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[/] No	Hospitel: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[/] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[/] Naturel 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1[/] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D0051301	December 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin B Knopf MD 900 Bestgate Road, Suite 300 Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 10 2001	Geneva G. Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42657

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN CHARLES PAPE

2. Date of Death: Month 12 Day 05 Year 2001

3. Time of Death: 7:30 PM

4a. Facility Name (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213-30-9241

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/14/1932

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE'S

10c. City, Town or Location: STEVENSVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 224 PENNICK DRIVE

10f. Zip Code: 21666

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FLIGHT ENGINEER

16b. Kind of Business/Industry: AVIATION

17. Father's Name (First, Middle, Last): HORACE WEST PAPE

18. Mother's Name (First, Middle, Maiden Surname): SOPHY BAUCH

19a. Informant's Name/Relationship (Type, Print): WANDA PAPE / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 224 PENNICK DRIVE STEVENSVILLE, MARYLAND 21666

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION

Date: 12/7/2001

20c. Location - City or Town, State: STEVENSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Thomas K. Helfenbein

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MARYLAND 21619

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — Approximate Interval Between Onset and Death: 1 Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: I. Weinstein

29c. License number: D38445

29d. Date signed (Month, Day, Year): Dec 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira Weinstein 60C Ridgely Ave, Annapolis, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 10 2001

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42658

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Delores Grace Rock

2. Date of Death Month / Day / Year: December 27 2001

3. Time of Death: 1530

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-28-5563

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 8, 1932

9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Residance of Decedant

10a. Stata: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 11403 Stonecroft Court, Apt. 216A

10f. Zip Coda: 21742

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yasr or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, Whita, atc. *Specify:* white

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 12; Collega (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: inspector

16b. Kind of Businass/Industry: clothing mfg.

17. Fsthar's Nama *(First, Middla, Last)*: Robert C. Martin

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Grace unknown

19a. Informant's Name/Ralationship *(Type, Print)*: David Rock - son

19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 132 E. Irvin Ave., Hagerstown, Md. 21740

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donstion 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: Beaver Creek Cemetery

Data: 12/30/01

20c. Location - City or Town, Stata: Beaver Creek, Md.

21. Signature of Funeral Service Licensee: Scott Minnich

22. Nama and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batwaen Onsat and Death

Immadiata Causa (Final diseasa or condition resulting in desth):
a. LUNG CANCER — 9M
Dua to (or as s consaquence of):
b. CHRONIC OBSTRUCTIVE LUNG DISEASE — 20Y
Dua to (or as a consaquence of):
c. CONGESTIVE HEART FAILURE — 5Y
Dua to (or as a consaquence of):
d.

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Lsst

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings avsilable prior to complation of causa of daath? 1☐ Yas 2☑ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Chack only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as ststed. 2☐ **Medical Examiner**: On tha basis of axamination snd/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of certifier

29c. Licansa number: 052323

29d. Data signed *(Month, Day, Year)*: 12/28/01

30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print): Dr Waseem 19414 C Leitersburg Pike Hagerstown Maryland

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 28 2001

32. Registrar's Signatura: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42659

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLA MAE RICHARDSON
2. Date of Death (Month, Day, Year): 12 25 01
3. Time of Death: 5:16 Am
4a. Facility Name (If not institution, give street and number): Coffman Nursing Home
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 216-38-0575
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1938
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 17952-24 Garden Lane
10f. Zip Code: 21740
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professional Secretary
16b. Kind of Business/Industry: Manufacturing Company

17. Father's Name (First, Middle, Last): Don Hill
18. Mother's Name (First, Middle, Maiden Surname): Edna Peck

19a. Informant's Name/Relationship (Type, Print): Dennis Corapi/Son-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12918 Oak Hill Ave., Hagerstown, Maryland 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Pleasant Grove Cemetery
Data: Dec.28
20c. Location - City or Town, State: Warfordsburg, PA

21. Signature of Funeral Service Licensee: ▶ Douglas A Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one cauae on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finat disease or condition resulting in death)
a. Rectal Cancer — 3 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cauee of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ Michael J. McCormack MD
29c. Licansa number: D 41607
29d. Date signed (Month, Day, Year): 12-27-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. McCormack 11110 Medical Campus Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signeture: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42660

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gary Lee RICE

2. Date of Death (Month, Day, Year): Dec. 25, 2001

3. Time of Death: 1016 AM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-56-0907

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 27 1952

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Pennsylvania | 10b. County: Franklin | 10c. City, Town or Location: Greencastle | 10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3858 Coseytown Road | 10f. Zip Code: 17225 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1973-81

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: Industrial plant

17. Father's Name (First, Middle, Last): Robert L. Rice Sr.

18. Mother's Name (First, Middle, Meiden Surname): Maryetta Rutherford

19a. Informent's Neme/Reletionship (Type, Print): Sally Rice - Wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3858 Coseytown Road Greencastle, Pa. 17225

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bakersville Cemetery | Date: 12/28/01

20c. Location - City or Town, Stete: Bakersville, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. Acute Hepatic NECROSIS — 1 MONTH

Due to (or as a consequence of):
b. Acute Alcoholic Hepatitis

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Due to (or es a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

Acute RENAL FAILURE
Cirrhosis of Liver
Portal Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Dino J. Delapontas MD

29c. License number: D26523

29d. Date signed (Month, Day, Year): December 26, 2001

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): DINO J. DELAPORTAS MD 11110 MEDICAL CAMPUS ROAD HAGERSTOWN MARYLAND 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signeture: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Rice, Gary Lee

Amended
Item#7/SC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Per FH/WCHD 12-26-2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42661

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Dolores F. Randolph	12 / 22 / 2001	12:56 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital	Balto, MD	Balto.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
110 22 5013	1☐M 2☒F	~~72~~ 73 Yrs.			2/22/1928	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5405 Lynview Ave.	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Registered Prof. Nurse	Health Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Campher	Catherine Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lee Robert Randolph	5405 Lynview Ave. Baltimore, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rose Hill Cem.	12/28/2001	Hagerstown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Mary DeWatson	Watsons Funeral Home PO Box 856 Hagerstown, MD 21740

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Lung Cancer

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☒Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Steven Miller, MD	043152	December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Miller 1717 Gwynn Oak Ave Balto. MD 21207

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42662

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: William Richard Rasche, Sr.

2. Dete of Death Month: December Dey: 20 Year: 2001

3. Time of Death: 7:35PM

4a. Facility Neme *(If not institution, give street and number)*: Glade Valley Nursing & Rehabilitation Ctr.

4b. City, Town, or Location of Death: Walkersville

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216--20-1639

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 77 Yrs. If Under 1 Year Months: Deys: If Under 24 Hrs. Hours: Min.:

8. Dete of Birth *(Month, Day, Year)*: July 20, 1924

9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Carroll

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1207 Hapes Mill Rd.

10f. Zip Code: 21787

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent'a Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: farmer

16b. Kind of Business/Industry: agriculture

17. Fether's Neme *(First, Middle, Last)*: August Michael Rasche

18. Mother's Neme *(First, Middle, Maiden Surname)*: Katie Hudson

19e. Informent's Neme/Reletionship *(Type, Print)*: Doris S. Rasche/ wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1207 Hapes Mill Rd. Taneytown, MD 21787

20e. Method of Disposition: 1☒ Burlel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Pipe Creek Cemetery

Dete: 12/24/01

20c. Location - City or Town, Stete: nr. Linwood, MD

21. Signeture of Funerel Service Licensee: Catharine O. Hartzler

22. Neme end Address of Feciliby: Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): a. Aspiration Pneumnia — days

Due to (or es e consequence of): b. Acholic Encephalopathy — years.

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

Due to (or es a consequence of): c.

Due to (or es a consequence of): d.

Pert II. **Other significent conditfons** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, etreet, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and mennar as etated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Allen J. Gilson MD

29c. License number: D26516

29d. Dete signed *(Month, Dey, Yeer)*: DEC 24 2001

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Allen J. Gilson MD 1475 TANEY AVE FREDERICK MD 21702

State Registrar

31. Dete filed *(Month, Day, Yeer)*: DEC 26 2001

32. Registrar's Signeture: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42663

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIRGINIA HOPE REEDER

2. Date of Death (Month, Day, Year): Dec 21 2001

3. Time of Death: 10:55 AM

4a. Facility Name *(If not institution, give street and number)*: Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 577-46-1415

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC 23 1918

9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 601 DUTCHMANS LANE

10f. Zip Code: 21601

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: EXECUTIVE SECRETARY

16b. Kind of Business/Industry: UNIVERSITY

17. Father's Name *(First, Middle, Last)*: FRANCIS HAVERTY

18. Mother's Name *(First, Middle, Maiden Surname)*: THERESA IRENE GARY

19a. Informant's Name/Relationship *(Type, Print)*: FRANK LYONS/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7220 FRANCES STREET, EASTON, MD 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: STEVENSVILLE CEMETERY

Date: 12-23-01

20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: JOHN R. MERLERO

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death) a. probable pneumonia — 5 days

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due fo (or as e consequenca of):

c.

Dua fo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diffuse arthritis
polymyalgia rheumatica
general deconditioning

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D25750

29d. Date signed *(Month, Day, Year)*: 12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT SANCHEZ, MD 508 IDLEWILD AVENUE EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 26 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Virginia Reeder
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42664

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Russell
2. Date of Death Month Day Year: December 27, 2001
3. Time of Death: 2:35 AM
4a. Facility Name *(If not institution, give street and number)*: 12533 Crystal Rock Terrace
4b. City, Town, or Location of Death: Germantown
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 233-32-5537
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Feb 19, 1924
9. Birthplaca *(State or Foraign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐ Yas 2☒ No
10a. Street and Number: 12533 Crystal Rock Terrace
10f. Zip Code: 20874
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Raca - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Administrative/Secretary
16b. Kind of Businass/Industry: Montgomery College

17. Father's Nama *(First, Middla, Last)*: Olen F deGruyter
18. Mothar's Name *(First, Middla, Maidan Surnama)*: Maude Hershman

19a. Informant's Name/Ralationship *(Type, Print)*: Kelly M. Russell/Daughter
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, State, Zip Coda)*: 1544 St Lawrence Court, Frederick, Maryland 21701

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar placa)*: Smithsburg Crematory | Data: Dec 27, 2001
20c. Location - City or Town, Stata: Smithsburg, MD

21. Signature of Funeral Service Licensee: Kurt Lynn Robertson M00706
22. Nama and Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Cause (Final disaasa or conditlon resulting in death): e. HEPATIC CARCINOMA — Months

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury thet initiated evants resulting in death) Last:

b. Dua to (or as a consequance of):

c. Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was case refarrad to medical axaminar? 1☐ Yas 2☒ No

26. Plece of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledga, daath occurrad at the time, date and plece, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, date and plece, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: Steven Dolinsky
29c. Licansa number: D20148
29d. Data signed *(Month, Day, Year)*: December 27, 2001

30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print): Steven H. Dolinsky, M.D., 911 Russell Avenue, Gaithersburg, Maryland 20879-3266

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42665

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bruce Arthur Rhoderick
2. Date of Death Month December Day 21 Year 2001
3. Time of Death: 1:26 P.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 471-46-2493
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 21, 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Myersville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10252 Rolling Ridge Court
10f. Zip Code: 21773
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance
18b. Kind of Business/Industry: County Education

17. Father's Name (First, Middle, Last): Joseph Rhoderick
18. Mother's Name (First, Middle, Maiden Surname): Mary Starner

19a. Informant's Name/Relationship (Type, Print): Ruth Rhoderick, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 201, Myersville, Maryland 21773

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: 12/24/2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: [signature] M00255
22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Brain Hemorrhage — Approximate Interval Between Onset and Death: 24 hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Hypertension
c. Due to (or as a consequence of): —
d. Due to (or as a consequence of): —

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) —
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D20922
29d. Date signed (Month, Day, Year): 12/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Prafulla Dave 188 Thomas Johnson Dr 200, Frederick, MD 21702

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42666

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEANNETTE RYDZEWSKI
2. Date of Death: Month: December Day: 18 Year: 2001
3. Time of Death: 1413
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-48-8886
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4825 Shellbark Road
10f. Zip Code: 21117
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registerd Nurse
16b. Kind of Business/Industry: Hospital

17. Father's Neme (First, Middle, Last): Casimer Rydzewski
18. Mother's Name (First, Middle, Maiden Surneme): Rosemary Hill Eser

19a. Informent's Neme/Retetionship (Type, Print): Rosemary Hill/Mother
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1306 Sylvia St., Salisbury, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Oak Lawn Cemetery
Dete: 12/21/01
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ David A. Thompson, CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in deeth)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as steted. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Clifford Faber MD
29c. License number: 024970
29d. Date signed (Month, Day, Year): DECEMBER 19, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): CLIFFORD FABER, MD 5401 OLD COURT ROAD RANDALLSTOWN, MARYLAND 21133

State Registrar

31. Date filed (Month, Day, Year): DEC 20 2001
32. Registrar's Signature: ▶ L Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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SMP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42667

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William NMN Sweet
2. Date of Death (Month, Day, Year): December 27, 2001
3. Time of Death: 0555
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 068-28-2216
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 21, 1934
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 191 Sunbrook Lane
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 01/1959 01/1965
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Agent
16b. Kind of Business/Industry: Airlines
17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Cora Shuler
19a. Informant's Name/Relationship (Type, Print): Barbara A. Sweet/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 191 Sunbrook Lane, Hagerstown, Maryland 21742
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rocky Gap Cemetery
Date: Jan. 2
20c. Location - City or Town, State: Cumberland, Maryland
21. Signature of Funeral Service Licensee: Douglas A Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home, 1331 Eastern Blvd., North, Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION — INSTANTANEOUS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cesa referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D40622
29d. Date signed (Month, Day, Year): DECEMBER 28, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EXPIRES 4 87 COMM - MD 1236 MEDICAL VIEW DR HAGERSTOWN

State Registrar

31. Data filed (Month, Day, Year): DEC 31 2001
32. Registrar's Signature: Renee D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Sweet, William

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42668

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Louise SHARER

2. Date of Death (Month, Day, Year): 12-24-01

3. Time of Death: 11:15 AM

4a. Facility Name (If not institution, give street and number): 226 S. Mulberry Street

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-14-2260

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 4 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 226 S. Mulberry Street

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Floor Supervisor

16b. Kind of Business/Industry: Clothing Mfg.

17. Father's Name (First, Middle, Last): Norman S. Grimes

18. Mother's Name (First, Middle, Maiden Surname): Katie Pearl Butts

19a. Informant's Name/Relationship (Type, Print): Donald Sharer - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 433 Clarendon Avenue Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Rose Hill Cemetery

Date: 12/18/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel diseese or condition resulting in death) a.	Cardiorespiratory Failure	Few Hours
Due to (or as e consequence of): b.	Ventricular Arrythmia	Few Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Congestive Heart Failure	Few Years
Due to (or as e consequence of): d.	Small Cell Carcinoma of Lung	Few Months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease
Peptic Acid Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: TA Casha MD

29c. License number: D35497

29d. Date signed (Month, Day, Year): 12.27.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TANVIR A. CASHA MD 376 MILL ST. HAGERSTOWN MD 21740

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42669

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Amelia SHANK
2. Date of Death: Month December Day 24 Year 2001
3. Time of Death: 5:25 p.m.
4a. Facility Name (If not institution, give street and number): Beverly Health Care
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 216-38-0330
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 4 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 86 Nottingham Road
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 5 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeping
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): George Feigley
18. Mother's Name (First, Middle, Maiden Surname): Florence Kelly

19a. Informant's Name/Relationship (Type, Print): Jane A. Jenkins - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 84 Nottingham Road Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Rest Haven Cemetery
Date: 12/28/01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Munnich
22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	5 Years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maryan Graf
29c. License number: D28365
29d. Date signed (Month, Day, Year): 12.25.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYAN J. SHARP 368 Mill Street Hagerstown MD 21740.

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42670

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHRYN FAY SHORT
2. Date of Death (Month, Day, Year): December 25, 2001
3. Time of Death: 1:30 PM
4a. Facility Name (If not institution, give street and number): Western Maryland Hospital Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 179-12-4139
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 2 1923
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 478 Pangborn Blvd.
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: County Government

17. Father's Name (First, Middle, Last): Chester Roberts
18. Mother's Name (First, Middle, Maiden Surname): Agnes (unknown)

19a. Informant's Name/Relationship (Type, Print): David Short - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 479 Links View Drive Hagerstown, Md. 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Hagerstown Crematory
Date: 12/26/01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CORONARY ARTERY DISEASE — 10 YEARS

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE LUNG DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ATHEROSCLEROSIS — YEARS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RECURRENT PNEUMONIAS
HYPERTENSION
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D 44996
29d. Date signed (Month, Day, Year): DECEMBER 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZAFAR MALIK MD. 1500 Pennsylvania Avenue Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42671

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Cora SANDERS
2. Date of Death (Month, Day, Year): DECEMBER 24 2001
3. Time of Death: 0727
4a. Facility Name (If not institution, give street and number): Homewood
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-16-1886
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 18,1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11920 Seminole Drive
10f. Zip Code: 21783
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): clerk
16b. Kind of Business/Industry: bakery

17. Father's Name (First, Middle, Last): Edgar F. Sprecher
18. Mother's Name (First, Middle, Maiden Surname): Bessie M. Longanecker

19a. Informant's Name/Relationship (Type, Print): Richard Sanders - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Eastview Drive, Hagerstown, Md. 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Mem. Park
Date: 12/28/01
20c. Location - City or Town, State: Hagerstown, Md.

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HIP FRACTURE — 6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION, LUPUS ANTICOAGULANT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 11-25-01
28b. Time of Injury: UNKNOWN M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: FELL AT NURSING HOME
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOMEWOOD NURSING HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): WILLIAMSPORT MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: MD
29c. License number: D40622
29d. Date signed (Month, Day, Year): 12-27-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRENDA L WISEMAN-MD 14286 MEADOW VIEW DR HAGERSTOWN

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Mildred C. Sanders
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

12-24-01 7:27 a.m.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42672

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OMER DANIEL SPRECHER JR.
2. Dete of Deeth: Month December Dey 21 Year 2001
3. Time of Death: 1:20 AM
4a Facility Name (If not institution, give street and number): Homewood at Williamsport
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-09-7895
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months Days | If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): October 6, 1917
9. Birthplace (State or Foreign Country): Maryland

Usuel Residenca of Decedent

10e. Stete: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1314 Oak Hill Avenue
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944-1947
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) | College (1-4or 5+): 8
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Physician-Surgeon
16b. Kind of Business/Industry: Medical Profession

17. Father's Name (First, Middle, Last): Omer Daniel Sprecher
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Juliet Keller

19e. Informant's Name/Relationship (Type, Print): Bernice G. Sprecher Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1314 Oak Hill Avenue, Hagerstown, Maryland 21742

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematorium
Dete: 12-22-2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: ▶ R. Noel Brady
22. Name and Address of Feciility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final diseese or condition resulting in deeth): a. Arteriosclerotic cardiovascular disease years
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as e consequence of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Stroke, multi infact dementia Parkinson disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: ▶ [signature] MD
29c. License number: D26806
29d. Date signed (Month, Day, Year): December 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] MD 747 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 2 6 2001
32. Registrar's Signature: ▶ Bernice G Sprecher

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42673

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALTER RAY SHEFFLER
2. Date of Death: Month DECEMBER Day 17, Year 2001
3. Time of Death: 13:06
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-18-0942
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 29, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 55 East Washington Street
10f. Zip Code: 21740
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner and Operator
16b. Kind of Business/Industry: Tavern

17. Father's Name (First, Middle, Last): Joseph Keller Sheffler
18. Mother's Name (First, Middle, Maiden Sumama): Nellie Theola Toms

19a. Informant's Name/Relationship (Type, Print): Judith T. Feiser Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21246 Leiters Mill Road, Hagerstown, Md. 21742

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): Rest Haven Cemetery
Date: 12-20-2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licansee: ▶ R. Noel Brady
22. Nama and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. EMPHYSEMA — 4 YEARS

Due to (or as a consequence of):
b. ACUTE RESPIRATORY FAILURE — 1 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last
c. BRONCHOGENIC CARCINOMA — 4 YEARS

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and manner as stated. 2 [✓] Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at tha time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ D. Wright Wooster
29c. License number: D0022043
29d. Date signed (Month, Day, Year): 12/19/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 11110 MEDICAL CAMPUS RD HAGERSTOWN MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 2 0 2001
32. Registrar's Signature: ▶ Deputy G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WALTER RAY SHEFFLER

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42674

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES NORRIS SMITH
2. Date of Death *(Month, Day, Year)*: DECEMBER 26, 2001
3. Time of Death: 10:15 PM
4a. Facility Name *(If not Institution, give street and number)*: CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 214-28-9022
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUGUST 17, 1927
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: WALDORF
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11320 RABY ROAD
10f. Zip Code: 20601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PAINTER/FOREMAN
16b. Kind of Business/Industry: PRINCE GEORGE'S COUNTY SCHOOL BOARD

17. Father's Name *(First, Middle, Last)*: JAMES CLINTON SMITH
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY LOUISE MORRISON

19a. Informant's Name/Relationship *(Type, Print)*: MARY EVELYN SMITH - WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11320 RABY ROAD, WALDORF, MARYLAND 20601

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: RESURRECTION CEMETERY — Date: 12-31-01
20c. Location - City or Town, State: CLINTON, MARYLAND

21. Signature of Funeral Service Licensee: JPK ▶ JOHN P. KNISLEY — M01164
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. – Acute Myocardial Infarction — 10 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Respiratory Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D-02975
29d. Date signed *(Month, Day, Year)*: DECEMBER 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANIEL M. HOWELL, M.D., 11345 PEMBROOKE SQUARE, SUITE 104, WALDORF, MD 20603

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42675

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Stickney

2. Date of Death Month Day Year: December 26, 2001

3. Time of Death: 8:26 A. M

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 074-26-9016

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul 13, 1931

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6020 Linganore Road

10f. Zip Code: 21701

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative

16b. Kind of Business/Industry: Defense Mapping Agency

17. Father's Name (First, Middle, Last): Jacob Wessel TenBroeck

18. Mother's Name (First, Middle, Maiden Surname): Cornelia Parker

19a. Informant's Name/Relationship (Type, Print): Mr. G. Malcolm Stickney/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6020 Linganore Road, Frederick, Maryland 21701

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Park Cemetery

Date: Dec 31,2001

20c. Location - City or Town, State: Hudson, New York

21. Signature of Funeral Service Licensee: Keith Lynn Roberson MO0706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASYSTOLE — 10 min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ACUTE MYOCARDIAL INFARCTION — 30 min.

Due to (or as a consequence of):

c. ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — UNKNOWN

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George I. Smith, M.D.; VPMA

29c. License number: D10587

29d. Date signed (Month, Day, Year): 12/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH, M.D. VICE-PRES MED AFFAIRS; FREDERICK MEMORIAL HOSP. FREDERICK, MD. 21701

10

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 42676
Reg. No.

Mary Catherine Stevens
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY CATHERINE STEVENS
2. Date of Death Month Day Year: December 19, 2001
3. Time of Death: 0240 M
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 214-12-6192
8. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/22/1917
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: QUEEN ANNE'S
10c. City, Town or Location: CHESTER
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1623 POSTAL ROAD
10f. Zip Code: 21619
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 7
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): FRANK LEWIS
18. Mother's Neme (First, Middle, Maiden Surneme): ARIE THOMPSON

19a. Informant's Name/Relationship (Type, Print): MARY ANN COURSEY / DAUGHTER
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 8319 BROADNECK ROAD CHESTERTOWN, MARYLAND 21620

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): STEVENSVILLE CEMETERY
Date: 12/21/2001
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ Chad M. Helfenbein
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MD 21619

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ALZHEIMER'S DEMENTIA — Approximate Interval Between Onset and Death: 10Y

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. Licanse number: D35284
29d. Date signed (Month, Dey, Year): 12/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREA ALLEN, MD 219 S. WASHINGTON STREET EASTON, MARYLAND 21601

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42677

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theophilus H Talbert

2. Date of Death: Month 12 Day 22 Year 01

3. Time of Death: 5 55 A

4a. Facility Name (If not institution, give street and number): Avalon Manor 14014 Marsh Pike

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 213123786

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/18/16

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 21655 Leiter Street

10f. Zip Code: 21742

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yas 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-Employed

16b. Kind of Business/Industry: New and Used Lefty's Furniture

17. Father's Name (First, Middle, Last): Walter Talbert

18. Mother's Name (First, Middle, Maiden Surname): Orpha Letta

19a. Informant's Name/Relationship (Type, Print): Geraldine Talbert / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21655 Leiter Street, Hagerstown, Md. 21742

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery

Date: December 24, 2001

20c. Location - City or Town, State: Hagerstown, Md.

21. Signature of Funeral Service Licensee: Eric L. Brown

22. Name and Address of Facility: Rest Haven Funeral Home 1601 Pennsylvania Ave. Hagerstown, Md. 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	PROSTATE CANCER	5Y
Due to (or as a consequence of): b.	DEHYDRATION	1M
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	HYPERTENSION	15Y
Due to (or as a consequence of): d.	DIABETES MELLITIS	10Y

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D52323

29d. Date signed (Month, Day, Year): 12/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khalid Waseem, MD 19414C Leitersburg Pike, Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42678

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RICHARD AARON THOMPSON	Dec 26, 2001	8:11p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Civista Medical Center	La Plata MD	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-66-8621	1 [X] M 2 [ ] F	50 Yrs.			NOV. 18, 1951	WASHINGTON, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	CHARLES	WALDORF	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
149 JEFFERSON ROAD	20602	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		MECHANIC	AUTOMOTIVE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN E. THOMPSON, SR.	MARY ELEANOR SAVOY THOMPSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LOUISE PROCTOR/SISTER	149 JEFFERSON RD, WALDORF, MD 20602

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	RESURRECTION CEMETERY	01/02/02	CLINTON, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ LEON THORNTON	THORNTON FUNERAL HOME, PA 3439 LIVINGSTON RD, INDIAN HEAD, MD 20640

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	3 mo
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Daniel Howell MD	D-0002975	12-27-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel M Howell., MD 605 E. Charles st, La Plata, MD 20646

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 31 2001	▶ Penina D. Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Richard Thompson

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42679

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosalie Tierney
2. Date of Death (Month, Day, Year): December 23, 2001
3. Time of Death: 0955am M
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-46-6075
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun 09, 1911
9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2425 Bear Den Road
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management-Budget/Finance
18b. Kind of Business/Industry: Dept of Agriculture

17. Father's Name (First, Middle, Last): Gus Smith
18. Mother's Name (First, Middle, Maiden Surname): Josie Unknown

19a. Informant's Name/Relationship (Type, Print): Mrs. Deirdre Grant/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2425 Bear Den Road, Frederick, Maryland 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: Dec 24, 2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service License: Keith Lynn Robertson M00706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D16428
29d. Date signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline III, M.D, 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42680

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
MILDRED MARIE THOMAS	12	14	2001	2:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-30-9127	1☐M 2☒F	67 Yrs.			01/27/1934	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	QUEEN ANNE'S	CHESTER	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1705 CRAB ALLEY DRIVE	21619	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12		ADMINISTRATIVE ASSISTANT	GOVERNMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HOLLIS HUGHES HOPKINS	MARIE ALBERTA BANGS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
EDWARD Y. THOMAS / HUSBAND	1705 CRAB ALLEY DRIVE CHESTER, MARYLAND 21619

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	STEVENSVILLE CEMETERY	12/18/2001	STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Chad M. Fellows

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finet disease or condition resulting in death)	a. Acute myocardial infarction	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Dey / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
James Haarms MD	D41339	12-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES HAARMS MD 130 LOVE POINT RD STEVENSVILLE, MD 21666

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
DEC 19 2001	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42681

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Virginia WALKER

2. Date of Death: Month December Day 29 Year 2001

3. Time of Death: 4:13 AM

4a. Facility Name (If not institution, give street and number): Fahrney Keedy Nursing Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 233-09-3342

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 13, 1914

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 219 Alexander Street

10f. Zip Code: 21740

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-3 | College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: her own home

17. Father's Name (First, Middle, Last): Raymond Barthlow

18. Mother's Name (First, Middle, Maiden Surname): Lydia Virginia Stanley

19a. Informant's Name/Relationship (Type, Print): Anna L. Nave - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18215 Manor Church Road, Boonsboro, Maryland 21713

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory

Date: Dec. 31, 2001

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Fred L. Nuttall

22. Name and Address of Facility: Minnich Funeral Home, 415 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	PNEUMONIA	1W
Due to (or as a consequence of): b.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	25Y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	HYPERTENSION	25Y
Due to (or as a consequence of): d.	CORONARY ARTERY DISEASE	10Y

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Waseem

29c. License number: D52323

29d. Date signed (Month, Day, Year): 12/29/1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khalid M. Waseem, 19414-C Leitersburg Pike, Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001

32. Registrar's Signature: Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Elizabeth Walker

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42682

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES EDWARD WELCH

2. Date of Death (Month, Day, Year): December 24 2001

3. Time of Death: 0550

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-32-4787

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): JUNE 9, 1912

9. Birthplace (State or Foraign Country): VIRGINIA

Usual Residence of Decedent

10a. Stete: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: WILLIAMSPORT

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 214 S. CONOCOCHEAGUE ST.

10f. Zip Code: 21795

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 3 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMING

16b. Kind of Business/Industry: DAIRY FARM

17. Father's Name (First, Middle, Last): JAMES RIDINGS WELCH

18. Mother's Name (First, Middle, Maiden Surneme): LULA MAY MILLER

19a. Informent's Neme/Relationship (Type, Print): WILLIAM R. WELCH, BROTHER

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 214 S. CONOCOCHEAGUE ST., WILLIAMSPORT, MD 21795

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): BEAVER CREEK CEMETERY

Dete: DEC. 27, 2001

20c. Location - City or Town, State: HAGERSTOWN, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Nama and Address of Facility: BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, ahock, or heert failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediete Cause (Final disease or condition resulting in death)	a. Myocardial infarction	one week
Due to (or es a consequence of):	b. Coronary artery Disease	years
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avents resulting in death) Lest	c. Emphysema	years
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal failure

23b. Did tobacco uee contribute to the cauee of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware eutopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier:

29c. Licanse number: D44996

29d. Date signed (Month, Day, Year): December 25, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): LAFAR MALIK MD 20311 LAPPANS RD BOONSBORO, MD 21713

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 2 6 2001

32. Registrar's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Welsh Charles Edward

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42683

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RAE MOLLIE WEISS

2. Date of Death: Month December Day 20 Year 2001

3. Time of Death: 1600

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 176-07-3555

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: September 24, 1914

9. Birthplace *(State or Foraign Country)*: Pennsylvania

Usual Residance of Decedant

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 106 East Magnolia Avenue

10f. Zip Coda: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Sales Clerk

16b. Kind of Businass/Industry: Paper Products Business

17. Fathar's Nama *(First, Middla, Last)*: Isaac Morris

18. Mothar's Nama *(First, Middla, Maiden Surnama)*: Katherine Felman

19a. Informant's Name/Ralationship *(Type, Print)*: Richard M. Weiss Son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 13520 Overhill Drive, Hagerstown, Maryland 21742

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: B'Nai Abraham Cemetery | Date: 12-23-2001

20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: ▶ R. Noel Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not antar tha moda ot dying, such as cardiac or raspiretory arrast, shock, or haart tailura. List only one causa on each lina. | Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)

a. PULMONARY FIBROSIS — YEARS

Dua to (or as a consequance of):

b. CONGESTIVE HEART FAILURE — MONTHS

Sequentially list conditions, if any, leading to Immadiata causa. Entar Underlying Cause (Disease or injury that initiated avants rasulting in daath) Last

Dua to (or as a consequance of):

c. DIVERTICULOSIS - RECTAL BLEEDING — WEEKS

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was cesa refarred to medical examiner? 1☐ Yas 2☑ No

26. Placa of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☑ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yas 2☐ No | 28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Cartifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, data and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of cartifier: ▶ [signature] WOOSTER MD

29c. License number: D0022043

29d. Data signed *(Month, Day, Year)*: 12/21/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): 1110 MEDICAL CAMPUS RD HAGERSTOWN, MD 21742

WEISS, RAE / MORRIS

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 26 2001

32. Registrar's Signature: ▶ Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-6521-021
B.K.S
UNKNOWN 01-321
Laura M. Wasson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1 - For State Registrar

Reg. No. 2001 42684

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura Marian Wasson
2. Data of Death Month Day Yaar: NOV. 16, 2001
3. Tima of Death: 0915 AM
4a. Facility Nama (If not institution, give street and number): 10933 WOLFSVILLE ROAD
4b. City, Town, or Location of Death: MYERSVILLE
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 567-49-3402
6. Sex: 1☐M 2☒F
7. Aga (In yrs. last birthday): 39 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): June 23, 1962
9. Birthplaca (State or Foraign Country): California

Usual Residence of Decedent

10a. State: Md.
10b. County: Frederick
10c. City, Town or Location: Myersville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 10933 Wolfsville Rd.
10f. Zip Coda: 21773
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1☐Yas 2☒No Specify:
14. Raca - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired): Lobbyist
16b. Kind of Businass/Industry: Government

17. Father's Nama (First, Middle, Last): Glenn H. Wasson
18. Mother's Name (First, Middla, Maiden Surname): Thelma L. Lensch

19a. Informant's Name/Relationship (Type, Print): Glenn H. Wasson (Father)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1006 Valley Court Shepherdstown, WV. 25443

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemafary, cramatory or other placa): Smithsburg Crematory
Date: Dec. 21, 2001
20c. Location - City or Town, Stata: Smithsburg, Md.

21. Signature of Funaral Service Licensee: Dennis L. Davis
22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daath. Do not anter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one causa on aach tina.

Immediate Cause (Final disease or condition resulting in death): a. Smoke Inhalation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Intarval Batwaan Onsat and Daath:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of deeth 5☐Other (specify) 9☐Unknown
23d. Date of dalivary Month Day Yaar

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23e. Did tobacco usa contributa to tha causa of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy parformed? 1☒Yas 2☐No
24b. Wara autopsy findings availabla prior to completion of cause of death? 1☒Yas 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Ptace of Daath (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Homa 5☐Rasidence 6☒Othar (Specify) AT SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be datarmined
28a. Data of Injury (Month, Day Yaar): Found 11/16/01
28b. Tima of Injury: Found 9:15 AM
28c. Injury at Work? 1☐Yes 2☒No
28d. Dascribe how injury occurred: unknown
28e. Place of Injury - At home, farm, straet, factory, offica building, atc. (Specify): home
28f. Location (Street and Number or Rural Routa Number, City or Town, State): 10933 Wolfsville Road, Myersville Maryland

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. Licensa number: O.C.M.E
29d. Data signed (Month, Day, Year): NOV. 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001
32. Registrar's Signatura: Samuel G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42685

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Blanche Roseland WESTHAFER
2. Date of Death (Month, Day, Year): December 18, 2001
3. Time of Death: 5:10 p.m.
4a. Facility Name *(If not institution, give street and number)*: Homewood Nursing Home
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 441-10-5768
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 17, 1918
9. Birthplace *(State or Foreign Country)*: Oklahoma

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16505 Virginia Avenue
10f. Zip Code: 21795
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: secretary
16b. Kind of Business/Industry: aircraft mfg.

17. Father's Name *(First, Middle, Last)*: Loren C. Steel
18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Balthrope

19a. Informant's Name/Relationship *(Type, Print)*: Karen Betts - daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10507 Connor Dr., Williamsport, Md. 21795

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hagerstown Crematory
Date: 12-20-01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. RENAL FAILURE	1-2 WKS
Due to (or as a consequence of):	b. INABILITY TO SWALLOW WELL	LONG TIME
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. STROKE	11/29/01
Due to (or as a consequence of):	d. EMBOLUS	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen E. Metzler MD
29c. License number: D17067
29d. Date signed *(Month, Day, Year)*: 12/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen E. Metzler MD 70 Antrim Ave Hagerstown Md

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42686

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SIDNEY NICOLE WAGNER

2. Date of Death — Month: DECEMBER; Day: 18; Year: 2001

3. Time of Death: 21:00 PM

4a. Facility Name *(If not institution, give street and number)*: CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: NONE

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 0 Yrs. — If Under 1 Year: Months 0, Days 0; If Under 24 Hrs.: Hours 2, Min. 20

8. Date of Birth *(Month, Day, Year)*: DEC. 18, 2001

9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: MILLERS

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4055 SCHALK ROAD # 2

10f. Zip Code: 21102

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: (INFANT)

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: JAMES RICHARD WAGNER III

18. Mother's Name *(First, Middle, Maiden Surname)*: ANITA ARLEENE MANN

19a. Informant's Name/Relationship *(Type, Print)*: ANITA A. WAGNER/MOTHER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4055 SCHALK RD #2 MILLERS, MD 21102

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MANCHESTER LUTHERAN CEMETERY

Date: 12/20/01

20c. Location - City or Town, State: MANCHESTER, MD

21. Signature of Funeral Service Licensee: Susan Flaherty Myers

22. Name and Address of Facility: MYERS FUNERAL HOME 91 WILLIS STREET WESTMINSTER, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PRETERM DELIVERY

Due to (or as a consequence of):

c. PRETERM LABOR

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chris Ballas

29c. License number: D37752

29d. Date signed *(Month, Day, Year)*: DECEMBER 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRIS BALLAS, M.D. 688 POOLE ROAD, WESTMINSTER, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WIR 1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42687

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LILLIAN A. WHITELEY	DECEMBER 20 2001	1:05 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-07-3609	1☐M 2☒F	86 Yrs.			DEC 22 1914	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	PRINCE GEORGES	LAUREL	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
910 PHILIP POWERS DR	20707	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GEORGE A. ANDERS	MABEL H. ERSKINE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ALAN L. WHITELEY/SON	2229 DAISY RD, WOODBINE, MD 21797

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	WOODLAWN MEMORIAL PARK	01-03-02	EASTON, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ JOHN R. MERCER	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MESENTERIC ISCHEMIA	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. MYOCARDIAL INFARCTION	
	Due to (or as a consequence of):	
	c. OVARIAN CANCER	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Paul Mackoul	47612	12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL MACKOUL M.D. 8218 WISCONSIN AVE BETHESDA, MD 20814

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Barbara G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

580

RKD

01-7391-021

BRIAN

WACHTER UNPENDED 012302:ITEMS#23a,27,28a-f pr ME G803 ss

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42688

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): BRIAN MICHAEL WACHTER

2. Dete of Death — Month: DECEMBER Dey: 31, Yeer: 2001

3. Time of Death: 3:52P.M.

4e Facility Neme (If not institution, give street and number): 805 E.MAIN STREET

4b. City, Town, or Location of Deeth: THURMONT

4c. County of Deeth: FREDERICK

Funeral Director

5. Social Security Number: 217-13-2225

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 21 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Sept. 10, 1980

9. Birthplace (Stete or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 13323 Jimtown Road

10f. Zip Code: 21788

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Auto Detailer

16b. Kind of Business/Industry: Bill's Auto Body Shop

17. Fether's Neme (First, Middle, Last): William Edward Wachter

18. Mother's Neme (First, Middle, Meiden Surneme): Janie Mae Price

19e. Informent's Neme/Reletionship (Type, Print): William E. Wachter (Father)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 13323 Jimtown Road, Thurmont, Maryland 21788

20a. Method of Disposition: 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other place): Smithsburg Crematory

Dete: 1/3/02

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signeture of Funerel Service Licensee: Robert E. Dailey Jr.

22. Neme and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heed failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death): a. METHADONE INTOXICATION ASSOCIATED WITH HYPOTHERMIA

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24e. Wes en eutopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Plece of Death (Check only one): Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Menner of Deeth: 1 ☐ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☒ Could not be determined

28a. Dete of Injury (Month, Dey Yeer): Found: 12-31-01

28b. Time of Injury: Found: 3:45p M

28c. Injury et Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: Unknown

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): Playground

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete): 805 E. Main St., Thurmont, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es ststed. 2 ☒ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Marjorie McHale

29c. License number: O.C.M.E.

29d. Dete signed (Month, Dey, Yeer): JANUARY 1,2002

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Mary Pontis A. Korell MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 0 S 2002

32. Registrer's Signeture: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42689

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Floyd Newton Wilt
2. Date of Death (Month, Day, Year): December 24 2001
3. Time of Death: 3 AM
4a. Facility Name (If not institution, give street and number): Prince Georges Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 229-18-5919
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 15, 1925
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Loudoun
10c. City, Town or Location: Leesburg
10d. Inside City Limits: XX Yes 2 No
10e. Street and Number: 25 Monroe Street # 220
10f. Zip Code: 20175
10g. Citizen of What Country?: U.S. of America

11. Marital Status: XX 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Weight & Balance Engineer
16b. Kind of Business/Industry: Airlines

17. Father's Name (First, Middle, Last): William Brown Wilt
18. Mother's Name (First, Middle, Maiden Surname): Emma Frances Newton Wilt

19a. Informant's Name/Relationship (Type, Print): Dale Cooper/niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 43335 Lost Corner Road, Leesburg, Virginia 20176

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Pleasant Cemetery
Date: 12/28/01
20c. Location - City or Town, State: Taylorstown, Virginia

21. Signature of Funeral Service Licensee: William J. Mahoney
22. Name and Address of Facility: 158 Catoctin Circle Leesburg, Virginia 20175

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

Respiratory Failure Ventilator Dependence

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul A. DeNorc MD
29c. License number: D01852
29d. Date signed (Month, Day, Year): DECEMBER 24 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A DENORE MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 42690

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Janis Louise Wertheimer	December 22, 2001	7:34 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-30-9917	1☐M 2☒F	93 Yrs.			Aug. 20, 1908	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8 West 3rd Street	21701	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Vice President	insurance & real estate

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Edward Miller	Dessie Putman Miller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert Hooper, co-executor	8 West 3rd Street, Frederick, MD 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Olivet Cemetery	12/28/2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ryan M. Beegan M00999	Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	6 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Hypertension	10 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary emboli

Diabetes

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Austin Pearre Jr.	D09689	12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Austin Pearre Jr. MD 300 W Ninth Street Frederick, MD

12

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Bonnie G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Robert Wootten
CJ
01-7394-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42691

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Robert	Wootten	Dec. 31 2001	5:10 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Univ.of Maryland Medical System	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yeer)	9. Birthplace (State or Foraign Country)
218-20-7007	1☒M 2☐F	76 Yrs.			5-6-1925	DE.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	WORCESTER	SNOW HILL	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3919 PAW PAW CREEK RD.	21863	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - Americen Indian, Black, White, atc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yas 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		SHIPPING CLERK	BUSINESS FORMS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
JAMES McKINLEY WOOTTEN	MADELINE MARVEL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JUANITA B. WOOTTEN / WIFE	3919 PAW PAW CREEK RD. SNOW HILL MD. 21863

20a. Method of Disposition	20b. Place of Disposition (Name of cematary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	SPENCE BAPTIST CHURCH CEM.	1/3/02	SNOW HILL, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ W. KIRK BURBAGE PER DVR.	BURBAGE FUNERAL HOME 208 W. FEDERAL ST. SNOW HILL MD. 21863

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each lina.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Subarachnoid Hemorrage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residance 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	12/16/01	16:33 PM	1☐Yes 2☒No	Driver in accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street end Number or Rural Route Number, City or Town, State): Public Landing and Mt. Wesley Road Snow Hill, MD

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner;** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Matthew Warden	P14001	Jan. 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATTHEW WARDEN 22 S. Greene St. Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 0 9 2002	▶ G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42692

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MAXINE ELEANOR YOUNKINS
2. Date of Death (Month, Day, Year): DECEMBER 21, 2001
3. Time of Death: 1205
4a. Facility Name *(If not institution, give street and number)*: 5710 MT. CARMEL CHURCH ROAD
4b. City, Town, or Location of Death: KEEDYSVILLE
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 213-40-4888
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 12, 1919
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: KEEDYSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5710 MT. CARMEL CHURCH ROAD
10f. Zip Code: 21756
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Fathar's Nama *(First, Middle, Last)*: HARRY R. HUFFER
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA M. REMSBURG

19a. Informant's Name/Relationship *(Type, Print)*: GAY C. BARTLETT, DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1827 ROHRERSVILLE ROAD, KNOXVILLE, MARYLAND 21758

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BROWNSVILLE HEIGHTS CEM. — Date: DEC. 27, 2001
20c. Location - City or Town, State: BROWNSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Kelly A. Zimmerman
22. Nama and Address of Facility: BAST FUNERAL HOME, 7606 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 21713

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on aach line. — Approximate Interval Between Onsat and Death

Immediate Cause (Finat disaase or condition resulting in death)
a. CARCINOMA OF THE RENAL PELVIS — 6 months

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa refarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. McCormack MD
29c. License number: D41667
29d. Date signed *(Month, Day, Year)*: December 24, 2001

30. Nama and address of person who completed cause of death (item 23a) (Type, Print): Michael J. McCormack 11110 Medical Campus Rd., Hagerstown, Maryland 21742

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signature: Jeanne B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-7389-033
DORIS ANN DISNEY
CC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42693

UNPENDED 030702: ITEMS #23a, ptII, 27 per ME G805 ss

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris Ann Disney
2. Date of Death Month Dey Yeer: DECEMBER 31, 2001
3. Time of Death: 0858 a
4a. Facility Name *(If not institution, give street and number)*: 1003 PHILLIP POWERS DRIVE
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 218-52-5144
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 54 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: July 2, 1947
9. Birthplece *(State or Foreign Country)*: Tennessee

Usuel Residence of Decedant

10a. Stete: MD
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1003 Phillip Powers Drive
10f. Zip Coda: 20707
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Grade 11 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager
16b. Kind of Businass/Industry: School Cafeteria

17. Father's Name *(First, Middle, Last)*: John C. Freeman, Sr.
18. Mother's Nema *(First, Middle, Maiden Sumame)*: Gladys R. Gatewood

19a. Informent's Neme/Reletionship *(Type, Print)*: John L. Disney, III / spouse
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1003 Phillip Powers Drive Laurel, Maryland

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donetion 5☐ Othar *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Carters Valley Cemetery
Dete: 1/7/02
20c. Location - City or Town, State: Surgoinsville, TN

21. Signature of Funeral Service Licensee: ▶ [signature] / M00770
22. Name end Address of Fecility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, MAryland 20707

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximata Intervel Between Onsat and Death

Immediata Causa (Final disease or condition resulting in death)
a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Dua to (or as a consaquanca of):
b.
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PATCHY (FOCAL) BRONCHOPNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No
24b. Were eutopsy findings eveilable prior to completion of cause of daeth? 1☒ Yes 2☐ No

25. Was casa rafarred to medical examiner? 1☒ Yes 2☐ No
26. Placa of Deeth *(Check only ona)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☒ Residance 6☐ Othar *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, end due to tha causa(s) and menner as stated. 2☒ **Medical Examiner**: On the besis of examinetion and/or investigation, in my opinion, death occurred at tha time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ [signature], M.D.
29c. License number: OCME
29d. Data signed *(Month, Dey, Year)*: JANUARY 1, 2002

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 10 2002
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42694

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Danielle Renee Emory

2. Date of Death Month Day Year: November 25, 2001

3. Time of Death: 5:10 AM

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 216-23-6668

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 17 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth (Month, Day, Year): Dec. 4, 1983

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Queen Annes

10c. City, Town or Location: Centreville

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 328 South Commerce Street

10f. Zip Code: 21617

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Corning Revere

17. Father's Name (First, Middle, Last): Charles S. Emory / Father

18. Mother's Name (First, Middle, Maiden Surname): Brenda Thomas

19a. Informant's Name/Reletionship (Type, Print): Charles S. Emory / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 328 South Commerce Street, Centreville, Md. 21617

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Chesterfield Cem.

Date: 12/01/2001

20c. Location - City or Town, State: Centreville, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. multi trauma with Complications

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of): Wayne McKnell MD

CERTIFICATION APPROVED BY MEDICAL EXAMINER

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): 11-21-01

28b. Time of Injury: 1536 M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: MVC

28e. Place of Injury - At home, ferm, street, factory, office building etc. (Specify): RT 301 + 50, Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Rts 301+50 Queen Anne County

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P 15934

29d. Date signed (Month, Day, Year): 11/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): L. Sink 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2002

32. Registrar's Signature: Brenda D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CPM
01-7295-510
DOROTHY GREENE

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42695

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy B. Greene
2. Data of Death (Month Day Year): DECEMBER 24, 2001
3. Time of Death: 16:16
4a. Facility Name (If not institution, give street and number): 3603 WABASH AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 212-16-9616
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 01 30 16
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3603 Wabash Ave
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): 4 yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary
16b. Kind of Business/Industry: C & P Telephone Co.

17. Father's Name (First, Middle, Last): Robert Bailey
18. Mother's Name (First, Middle, Maiden Surname): Rebecca Flowers

19a. Informant's Name/Relationship (Type, Print): Cleotus Bailey-Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7706 Eden Roc Way, Pikesville Md 21208

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 1/3/02
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Jakubowski Jr.
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2002
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42696

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Virginia Lee Israel	December 31, 2001	3:41 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-72-1326	1☐M 2☒F XX	91 Yrs.			June 20, 1910	Florida

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Laurel	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
203 Patuxent Road	20707	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3 years	Registered Nurse	Health Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Sharpe Lee	Mary A. Seabrook

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Stephen S. Israel / son	5905 Ians Way Kingstowne, Virginia 22315

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ivy Hill Cemetery	Jan. 5, 2002	Laurel, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] / M00770	Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Electromechanical Dissociation	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Artery Disease	15 years
	Due to (or as e consequence of):	
	c. Diabetes Mellitus	20 years
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Wes decedent pregnant in the pasl 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute lo the cause of death? 1☐Yes 2☒No XX 3☐Probebly 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2XXNo

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the besl of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Anthony P. Zavadil III MD	D34149	January 2, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony P. Zavadil, III 14201 Laurel Park Drive #214 LAurel, MAryland 20707

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
JAN 10 2002	▶ Renee D Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

LANIUS

VOID

CERTIFICATE #

01-42697

SEE

CERTIFICATE #

02-00702

01-7228-031
B.K.S
EDWARD MURPHY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 42698

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Murphy
2. Date of Death (Month, Day, Year): DEC. 20, 2001
3. Time of Death: 0832 AM
4e. Facility Name (If not institution, give street and number): 8100 CONNECTICUT AVENUE
4b. City, Town, or Location of Death: CHEVY CHASE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 050-18-3821
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 30, 1921
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8100 Connecticut Ave. #623
10f. Zip Code: 20814
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Man
16b. Kind of Business/Industry: Law Enforcement
17. Father's Name (First, Middle, Last): Thomas W. Murphy
18. Mother's Name (First, Middle, Maiden Surname): Edna Smith
19a. Informant's Name/Relationship (Type, Print): Edward Murphy/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10204 Iron Gate Potomac, MD 20854
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Calverton National Cemetery
Date: 12/21/01
20c. Location - City or Town, State: Long Island, NY
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCourt & Trudden Funeral Home 385 Main St Farmingdale, NY 11735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Contact gunshot wound of the head
Due to (or as a consequence of):
b. Depression
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify) AT SCENE
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): Found 12-20-2001
28b. Time of Injury: unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject shot self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 8100 Connecticut Avenue Montgomery County, Maryland
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature], M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): DEC. 20, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a P ER PHY G803 1/10/02 JH

Certificate of Death

Reg. No. 2001 42699

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Charles Reynolds	December 18 2001	11:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
14218 Greene Road	Baldwin	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-40-3452	1☒M 2☐F	59 Yrs.			7-5-1942	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baldwin	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
14218 Greene Road	21013	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	Disabled	Disabled

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles N. Reynolds	Dorothy E. Kauminski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Richard Reynolds/Brother	143 Rodeo Circle Baltimore MD 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Stete
1☒Buriel 2☐Cremation 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)	Sacred Heart of Jesus	12/20/01	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death)	a. ~~END STAGE INSULIN DEPENDENT DIABETIC NEPHROPATHY~~ ~~ON HEMODIALYSIS~~	
Due to (or as e consequence of):	b. DIABETIC KETOACIDOSIS - Heeled at GBMC	12.13.01
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	c. BILATERAL AMPUTATION - LOWER EXTREMITIES	12.13.01 2yr
Due to (or as e consequence of):	d. PERIPHERAL VASCULAR DISEASE.	

ACUTE MYOCARDIAL INFARCTION

IF FEMALE: 23b. Wes decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth?	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐Yes 2☐No 3☐Probebly 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ Ceballos, MD	D 25886	December-18-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LILIA CEBALLOS, M.D - O'DEA MEDICAL ARTS - 7505 - OSLER DR SUITE - 501 TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 2002	▶ D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42700

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RIKKI LASHAUN THORNTON
2. Date of Death (Month, Day, Year): November 22, 2001
3. Time of Death: 1528
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: NONE
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months: 0 Days: 9
If Under 24 Hrs.: Hours: Min.:
8. Date of Birth (Month, Day, Year): November 13, 2001
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6104 42D AVE. Apt. A203
10f. Zip Code: 20781
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): NONE
College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INFANT
16b. Kind of Business/Industry: INFANT

17. Father's Name (First, Middle, Last): Regall Thornton
18. Mother's Name (First, Middle, Maiden Surname): Rachelle Snyder

19a. Interment's Name/Relationship (Type, Print): Rachelle Snyder, mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6104 42D Ave. Apt. A203 Hyattsville MD 20781

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Stericycle
Date: 12-22-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Shady Grove Adventist Hospital 9901 Medical Center Dr. Rockville MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Extreme Prematurity	9 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Severe Intra Ventricular Hemorrhage	6 days
Due to (or as a consequence of):		
c.	Sepsis	6 days
Due to (or as a consequence of):		
d.	Severe Respiratory Distress Syndrome	9 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D43225
29d. Date signed (Month, Day, Year): November 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MADHU NIGAM, MD, Shady Grove Adventist Hospital, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2002
32. Registrar's Signature: ▶

KB

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42701

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Naomi Flannagan Walker
2. Date of Death — Month: July Day: 2 Year: 2001
3. Time of Death: 17:15
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: n/a
6. Sex: 1☐ M 2☒ F
7. Age *(in yrs. last birthday)*: n/a Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min. 10
8. Date of Birth *(Month, Day, Year)*: July 2, 2001
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7613 Milligan Lane
10f. Zip Code: 20735
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: n/a
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Bieck, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): n/a — Collega (1-4or 5+): n/a
16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: n/a
18b. Kind of Business/Industry: n/a

17. Fether's Name *(First, Middle, Last)*: Kevin Walker
18. Mother's Name *(First, Middle, Maiden Surname)*: Erica Renee Flannagan

19e. Informant's Name/Relationship *(Type, Print)*: Erica Renee Flannagan
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 7613 Milligan Lane 20735 Clinton, MD

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Stericycle
Dete: 8/1601
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Servica Licansee:
22. Nama and Address of Facility: 9901 Medical Center Drive Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on eech line. — Approximete Intervel Between Onsat and Death

Immediete Ceuse (Finel disease or condition resulting in death)
e. Septic Abortion
Due to (or es e consequence of):
b. Premature Rupture of Membranes, Preterm
Sequantially list conditions, if eny, leeding to immediate cause. Entar Underlying Ceuse (Diseesa or injury thet initiatad avents rasulting in deeth) Lest
Due to (or es e consequence of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying causa givan in Pert I.: n/a

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware eutopsy findings aveiiebla prior to completion of causa of daath? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yas 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturai 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*: n/a
28b. Time of Injury: M
28c. Injury et Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowiedge, death occurred at the time, dete end piece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, daath occurred et tha tima, data and ptece, end due to the cause(s) and manner steted.

29b. Signature end title of certifier:
29c. License number: R134514
29d. Dete signed *(Month, Dey, Year)*: 11/30/01

30. Name and address of person who completed cause of daeth (Item 23e) (Type, Print): Margaret Green 6506 Bells Mill Road Bethesda, MD 20817

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 10 2002
32. Registrer's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42702

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucille Winn

2. Date of Death: Month 12 Day 20 Year 01

3. Time of Death: 7:35 am

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Md.

Funeral Director

5. Social Security Number: 215-28-7114

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5-5-18

9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Md.

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2226 N. Calvert Street

10f. Zip Code: 21218

10g. Citizen of What Country? U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Blk.

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HouseKeeper

16b. Kind of Business/Industry: Housekeeping

17. Father's Name (First, Middle, Last): Willie Evans

18. Mother's Name (First, Middle, Maiden Surname): Daphine Simmon

19a. Informant's Name/Relationship (Type, Print): Shirley Winn - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2226 N. Calvert Street/Balto, Md 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion

Date: 12/27/01

20c. Location - City or Town, State: Balto, Md

21. Signature of Funeral Service Licensee: Lori Carroll

22. Name and Address of Facility: Irvin Carroll Funeral Home, 1712 W. North Avenue/Balto, Md 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. congestive heart failure

Due to (or as a consequence of):
b. Diabetic mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Anemia

Due to (or as a consequence of):
d. Sacral ulcer

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 30115

29d. Date signed (Month, Day, Year): 1/2/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. Ohiokpehai, MD 2600 Liberty Heights Ave Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2002

32. Registrar's Signature: Emma B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42703

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Philip Alexander
2. Date of Death (Month, Day, Year): December 20, 2001
3. Time of Death: 6:45 PM
4a. Facility Name *(If not institution, give street and number)*: 5725 Mayfair Manor Drive
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 058-36-6556
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 27, 1936
9. Birthplace *(State or Foreign Country)*: Egypt

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5725 Mayfair Manor Drive
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 5
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: Chemical

17. Father's Name *(First, Middle, Last)*: Alexander Phillip Frangoudis
18. Mother's Name *(First, Middle, Maiden Surname)*: Angela Volonassis

19a. Informant's Name/Relationship *(Type, Print)*: Michele Alexander (Hindi) /Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5725 Mayfair Manor Drive, Rockville MD 20852

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Chesapeake Crematory — Date: Dec 22, 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stella D Schneeman M00382
22. Name and Address of Facility: Rapp Funeral And Cremation Services 933 Gist Avenue Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lewy Body Disease — 7 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Anthony I. Corvelli
29c. License number: D00235
29d. Date signed *(Month, Day, Year)*: December 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony I. Corvelli. M.D. 5530 Wisconsin Ave., #1400 Chevy Chase, MD 20815

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 24 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42704

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alphonso G. Andrews, Sr.

2. Data of Death (Month, Day, Year): December 20, 2001

3. Time of Death: 3:01 AM

4a. Facility Name (If not institution, give street and number): Prince George's General Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 580-03-0928

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Nov. 28, 1918

9. Birthplace (State or Foreign Country): St. Croix, VI

Usual Residence of Decedent

10a. State: VI

10b. County:

10c. City, Town or Location: St. Croix

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: # 2 A Estate Concordia Christiansted

10f. Zip Code: 00820

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Property Procurement

16b. Kind of Business/Industry: Assistant Commissioner

17. Father's Name (First, Middle, Last): Jonas Andrews

18. Mother's Name (First, Middle, Maiden Surname): Anesta Reid

19a. Informant's Name/Relationship (Type, Print): Alphonso Andrews, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00820: 3 Constitution Hill, Christiansted, St. Croix, VI

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cramatory or other place): Kingshill Public Cemetery | Date: 12/28/01

20c. Location - City or Town, State: Kingshill Christiansted St. Croix, VI

21. Signature of Funeral Service Licensee: Allen J. Woodall

22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine Street., Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — years

Due to (or as e consequance of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASPIRATION PNEUMONIA

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul A. DeVore

29c. Licensa number: DO 18552

29d. Date signed (Month, Day, Year): DECEMBER 20 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A DEVORE MD 4203 QUEENSBURY RD HYATTSVILLE MD 20781

State Registrar

31. Date filed (Month, Dey, Year): DEC 28 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42705

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD E. ABRIMS SR.

2. Date of Death: Month Dec Day 16 Year 2001

3. Time of Death: 3:25 AM

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-64-8559

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 23 1953

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 510 BEND CIRCLE ROAD

10f. Zip Code: 21061

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1972-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER

16b. Kind of Business/Industry: RELIABLE CONSTRUCTION

17. Father's Name (First, Middle, Last): RICHARD J. ABRIMS

18. Mother's Name (First, Middle, Maiden Surname): THELMA L. SMITH

19a. Informant's Name/Relationship (Type, Print): HELEN ABRIMS (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 510 BEND CIRCLE RD. GLEN BURNIE, MD. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): MARYLAND VETERAN CEMETERY

Date: 12/21/01

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Larry G. Reese No 483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MARYLAND 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	2 weeks
Due to (or as a consequence of): b.	End stage Renal Disease	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen House physician

29c. License number: D53662

29d. Date signed (Month, Day, Year): Dec 16 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): X/A0 21404 3007 E. Northern Parkway Baltimore 21214

State Registrar

31. Date filed (Month, Day, Year): DEC 19 2001

32. Registrar's Signature: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ABRIMS, Richard

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42706

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jesse L. Adams
2. Date of Death: Month December Day 14 Year 2001
3. Time of Death: 11:50 PM
4a. Facility Name (If not institution, give street and number): 8800 Walther Blvd. #3101
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-07-4061
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 18, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8800 Walther Blvd. #3101
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Developer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): Lena E. Arter

19a. Informant's Name/Relationship (Type, Print): Carl Brudin/trustee
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23 West Street Annapolis, MD 21401

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Park Cemetery
Date: 12/19/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Todd E. Miller
22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dehydration — Days / months

Due to (or as a consequence of):
b. CVA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CAD, HTN

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: DJ311J
29d. Date signed (Month, Day, Year): Dec 16th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Landsman 8800 Walther Blvd, Parkville MD 21234

State Registrar

31. Date filed (Month, Day, Year): DEC 19 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #1.Per Phys.PGC 1-3-02 cr

Certificate of Death

Reg. No. 2001 42707

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie ~~Isadore~~ Isadora L. Appling

2. Date of Death: Month December Day 23 Year 2001

3. Time of Death: 10:15 P.M.

4e. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-16-3020

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/16/06

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Md.

10b. County: P.G.

10c. City, Town or Location: Fairmount Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5908 L Street

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Lannal Linder

18. Mother's Name (First, Middle, Maiden Surname): Candis McClendon

19e. Informant's Name/Relationship (Type, Print): Willie L. Hampton,Sr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1102 60th Avenue,Fairmount Heights,Md. 20743

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Mem. Cem.

Date: 12/29/01

20c. Location - City or Town, State: Suitland, Md.

21. Signature of Funeral Service Licensee: Gary M. Pratt

22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C. 20019

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

CR

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death) e. CARDIOGENIC SHOCK — 24 HRS

Due to (or es e consequenca of): ACUTE MYOCARDIAL INFARCTION — 24 HRS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1. OLD MYOCARDIAL INFARCTION

2. DIABETES.

23b. Did tobacco use contributa to tha cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: David A. Gourlay MD.

29c. License number: D 28195

29d. Date signed (Month, Dey, Year): 12-24-01

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): DAVID A. GOURLAY, MD, 1450 MERCANTILE LN. LARGO, MD. 20774

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

State Registrar

31. Date filed (Month, Dey, Year): DEC 27 2001

32. Registrer's Signeture: Barbara B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42708

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Octavia Wilbur Anderson, Sr.

2. Date of Death (Month, Day, Year): Dec 22, 2001

3. Time of Death: 4:55 A.M.

4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 246 10 5717

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 19, 1920

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Temple Hills,

10d. Inside City Limits: 1☐Yes 2☐No XX

10e. Street and Number: 5901 Fisher Road Apt #11

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married XX Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mail Room Supervisor

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Edward Anderson

18. Mother's Name *(First, Middle, Maiden Surname)*: Alberta Bullock

19a. Informant's Name/Relationship *(Type, Print)*: Clinton Anderson (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5901 Fisher Road Apt #11, Temple Hills, MD 20748

20a. Method of Disposition: XX Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cemetery

Date: 12/31/2001

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: ▶ Stan G. Gith

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiorespiratory Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sever Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably XX Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D0014619

29d. Date signed *(Month, Day, Year)*: 12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mahmood Mohamadi, M.D. 6130 Oxon Hill Road Suite #204 Oxon Hill, MD 20745

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42709

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thelma Brown
2. Data of Death Month Day Yaar: December 27, 2001
3. Tima of Death: 8:00 AM M
4a. Facility Nama *(If not institution, giva street and number)*: Laurelwood Nursing Home
4b. City, Town, or Location of Daath: Elkton
4c. County of Deeth: Cecil

Funeral Director

5. Social Security Number: 216-28-1453
6. Sex: 1☐M 2☒F
7. Aga *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: April 5, 1927
9. Birthplace *(Stata or Foraign Country)*: Virginia

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐Yas 2☒No
10e. Street and Number: 475 Landing Lane
10f. Zip Coda: 21921
10g. Citizan of Whal Country?: United States

11. Marital Status: 1☒Nevar Married 2☐ Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Give Yaar or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Homemaker
18b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middle, Last)*: Al Brown
18. Mother's Name *(First, Middle, Maiden Surneme)*: Edna Mullins

19a. Informant's Name/Ralationship *(Type, Print)*: Ellis Lonabaugh/ Son
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 5 Conley Court, Elkton, Maryland 21921

20a. Mathod of Disposition: 1☐Burial 2☒Cremation 3☐Ramoval from Stata 4☐Donation 5☐Other *(Specify)*
20b. Placa of Disposition *(Nama of cemetery, crametory or othar placa)*: R.A. Ferris Company
Data: December 28, 2001
20c. Location - City or Town, Stata: West Chester Pennsylvania

21. Signeture of Funeral Service Licensee: Robert A. Ferris
22. Name and Addrass of Facility: Crouch Funeral Home 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only ona causa on aach lina.

Approximate Interval Betwean Onsal and Daath

Immediate Cause (Final disaase or condition resulting in daath)
a. metastatic Cancer of Lung

Sequentially list conditions, if any, laading to immedieta cause. Entar Undarlying Cause (Disease or injury thet initieted events resulting in daath) Last
Dua to (or as a consequenca of):
b. Dua to (or as e consequenca of):
c. Dua to (or as a consequance of):
d.

IF FEMALE:
23b. Wes decedent pregnent in the pest 12 months? 1☐Yas 2☐No 9☐Unknown
23c. If yas, outcoma of pregnancy 1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnency 4☐Pregnant at tima of death 5☐Othar *(specify)* 9☐Unknown
23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23e. Did tobacco use contributa to tha causa of death? 1☒Yas 2☐No 3☐Probably 4☐Unknown

24e. Was an autopsy performed? 1☐Yes 2☒No
24b. Wara autopsy findings available prior to compiation of causa of daath? 1☐Yas 2☐No

25. Was case rafarred to medical examiner? 1☐Yas 2☒No
26. Placa of Daath *(Chack only ona)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☒Nursing Homa 5☐Rasidence 6☐Othar *(Specify)*
27. Manner of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicide 5☐Panding investigation 6☐Could not be datermined
28a. Dete of Injury *(Month, Day Yaer)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. *(Specify)*
28f. Location *(Straet and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒**Certifying Phyaician:** To the best of my knowledge, death occurred at tha time, date and placa, and dua to tha cause(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, date and piece, and due to the cause(s) and mannar stated.
29b. Signatura and titla of certifier: M Saudenmo
29c. Licensa numbar: D26183
29d. Data signed *(Month, Day, Yaar)*: 12-27-01

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Madhu S. SACHDEV M.D. 118 North St, ELKton, Md. 21921

State Registrar

31. Data filed *(Month, Day, Yaar)*: DEC 28 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42710

NAME KNOWN TO PHYSICIAN BOOHER, PAUL EDWARD

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Edward Booher

2. Date of Death (Month, Day, Year): DECEMBER 25 2001

3. Time of Death: 8:35 A M

4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: PERRY POINT

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 412-46-7422

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 16, 1930

9. Birthplace (State or Foreign Country): Tennessee

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Port Deposit

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1880 Hopewell Road

10f. Zip Code: 21904

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Twelve Years; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Yellow Freight Lancaster, Pennsylvania

17. Father's Name (First, Middle, Last): Samuel Booher

18. Mother's Name (First, Middle, Maiden Surname): Toby Mae Hatcher

19a. Informant's Name/Relationship (Type, Print): Jewell H. Booher (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1880 Hopewell Road, Port Deposit, Maryland 21904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): St.Mark's Cemetery

Date: 12/29/01

20c. Location - City or Town, State: Perryville, Maryland

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL VASCULAR ACCIDENT — UNKNOWN

Due to (or as a consequence of):

b. SEIZURE DISORDER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Data of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA of LUNG

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

26a. Date of Injury (Month, Day Yaar)

26b. Time of Injury M

26c. Injury at Work? 1 [ ] Yes 2 [ ] No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D52739

29d. Date signed (Month, Day, Yaar): 12/25/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suresh Shandelya, M.D. VA MEDICAL CENTER HEALTH CARE SYSTEM, PERRY POINT, MD

State Registrar

31. Date filed (Month, Day, Yaar): DEC 27 2001

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

9+1VA

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42711

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Albert Blackburn, Sr.
2. Date of Death (Month, Day, Year): DECEMBER 25 2001
3. Time of Death: 7:55A M
4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death: PERRY POINT
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 212-16-1895
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 19, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: XX Yes 2 ☐ No
10e. Street and Number: 112 Hollingsworth Manor
10f. Zip Code: 21921
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 ☐ No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: Industrial

17. Father's Name (First, Middle, Last): Lewis Blackburn
18. Mother's Name (First, Middle, Maiden Surname): Lena McGlothlin

19a. Informant's Name/Relationship (Type, Print): Robert L. Blackburn/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32 Racine Road, North East, Maryland 21901

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Asbury Cemetery
Date: December 28, 2001
20c. Location - City or Town, State: Port Deposit, Maryland

21. Signature of Funeral Service Licensee: Robert L. Crouch
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ADULT FAILURE TO THRIVE — Approximate Interval Between Onset and Death: UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. LUNG MASS
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D52739
29d. Date signed (Month, Day, Year): 12/25/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suresh SHANDELYA, M.D. VA MARYLAND HEALTH CARE SYSTEM PERRY POINT, MD 21902

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME KNOWN TO PHYSICIAN: BLACKBURN, JAMES

from

6+1VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42712

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank J. Baiers

2. Date of Death: Month December Day 25 Year 2001

3. Time of Death: 3:45 AM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 190-07-9535

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 9, 1913

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedant

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 993 Lanna Way

10f. Zip Coda: 21401

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☒ Widowad 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 1 ☐ Yas 2 ☒ No Specify:

14. Raca - Amarican Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grada complated): Elementery/Secondery (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Pharmaceutical Sales

16b. Kind of Businass/Industry: Salesman

17. Father's Name (First, Middle, Last): Paul Baiers

18. Mother's Nama (First, Middle, Maiden Surnama): Pauline Norkus

19a. Informant's Name/Ralationship (Type, Print): Robert Baiers / Son

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 993 Lanna Way Annapolis, Maryland 21401

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Place of Disposition (Nama of camatary, crematory or other placa): Resurrection Cemetery

Data: 12/29/2001

20c. Location - City or Town, Stata: Clinton, Maryland

21. Signature of Funeral Service Licensee: Robert Blake

22. Nama and Address of Facility: George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not anter the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Interval Batwaen Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Coronary Artery disease — Months

Due to (or as a consequanca of):

b. Anemia — Months

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants resulting in death) Last

Due to (or as e consequenca of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Was case referred to medical examinar? 1 ☐ Yas 2 ☒ No

26. Placa of Daath (Check only ona)

Hospital: 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA

Othar: 4 ☐ Nursing Homa 5 ☐ Residanca 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding investigation 6 ☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one): 1 ☑ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, data and placa, and dua to the causa(s) and manner as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: N Iqbal M.D

29c. License number: D41978

29d. Data signed (Month, Day, Year): 12-26-2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Nader Tavakoli 4000 Mitchellville Rd A312 Bowie MD 20716

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signatura:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42713

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura Ann Bush

2. Date of Death: Month December, Day 22, Year 2001

3. Time of Death: 4:30A M

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 239-48-0363

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months, Days. If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Mar. 4, 1925

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4110 Silver Park Terrace

10f. Zip Code: 20746

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Joseph Merlton

18. Mother's Name (First, Middle, Maiden Surname): Annis Bishop

19a. Informant's Name/Relationship (Type, Print): Lillie Bush Wood - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4110 Silver Park Terr., Suitland, MD 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other): Gen. Washington National

Date: 12/29/2001

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: John T Stewart, III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Asystole

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. Coronary Artery Disease

Due to (or as a consequence of): c.

Due to (or as e consequence of): d.

IF FEMALE:

23b. Was decedent pregnent in the pest 12 months? 1☐ Yas 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cardiomyopathy

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 50454

29d. Date signed (Month, Day, Year): December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arastoo Yazdani, M.D. 9801 Georgia Ave., Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(4)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42714

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LAWRENCE BELL, SR.	12-20-01	4-20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LAUREL REGIONAL HOSPITAL	LAUREL	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
717-07-6597	1 X M 2 ☐ F	89 Yrs.			08-18-12	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	P.G.	Lanham	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5104 Baltimore Lane	20706	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Foreman	Railroad Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Webster Bell	Mildred Plater

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Theodore O. Bell / Son	2851 S. King Dr.# 1618, Chicago, Ill. 60616

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Ft. Lincoln Cem.	12/28/01	Brentwood, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Darry M. Coates	H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. BILATERAL ASPIRATION PNEUMONIA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. NEUROGENIC DYSPHAGIA.	6-days.
	Due to (or as a consequence of): c. CEREBRO-VASCULAR ACCIDENT.	
	Due to (or as a consequence of): d. HYPERTENSION	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HEMIPARESIS

COAGULAPATHY.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown	1 ☐ Yes 2 X No	1 ☐ Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Abdul Nayeem MD.	D-21294	12-20-01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ABDUL NAYEEM, M.D. 3450-FORT MEADE ROAD, SUITE 100, LAUREL, MD. 20724.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	Brenda D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

)! 01-7318-033
Preston Berry
TLC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 011102:items#23a,27,28a-f per ME G803 ss

Certificate of Death

Reg. No. 2001 42715

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PRESTON BERRY

2. Date of Death (Month, Day, Year): December 26, 2001

3. Time of Death: 02:30 a.m.

4a. Facility Name (If not institution, give street and number): Prince George's County Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-60-7720

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 14, 1947

9. Birthplace (State or Foreign Country): Wash.D.C.

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1321 Euclid St., N.W.

10f. Zip Code: 20002

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Byron Berry

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Jones

19a. Informant's Name/Relationship (Type, Print): Dorothy E. JOnes/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 561 Ashford St., #3 Brooklyn, N.Y. 11207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 1/5/02

20c. Location - City or Town, State: Wash. D.C.

21. Signature of Funeral Service Licensee: Barbara J. Jenkins

22. Name and Address of Facility: Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND ALCOHOL INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No X

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No X

25. Was case referred to medical examiner? 1☒ Yes 2☐ No XXX

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined X

28a. Date of Injury (Month, Day Year): Found: 12-26-01

28b. Time of Injury: Unknown M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Apartment

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4065 Minnesota Ave., Washington, DC

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X

29b. Signature and title of certifier: J. Clarke MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. CLARKE LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 0 2 2002

32. Registrar's Signature: Steven P. Gross

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SIDS S 0 0 0 0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42716

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert Francis Briscoe
2. Date of Death Month Day Year: December 26, 2001
3. Time of Death: 1405
4a. Facility Name *(If not institution, give street and number)*: 31702 Olivet Circle
4b. City, Town, or Location of Death: Galena
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 220-26-8567
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 17, 1928
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Galena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 31702 Olivet Circle
10f. Zip Code: 21635
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Currier
16b. Kind of Business/Industry: Car Manufacturing

17. Father's Name *(First, Middle, Last)*: George Briscoe
18. Mother's Name *(First, Middle, Maiden Surname)*: Charity Carroll

19a. Informant's Name/Relationship *(Type, Print)*: Wendy Robinson/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 31731 Olivet Circle, Galena, Maryland 21635

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, cramatory or other place)*: Olivet Hill Cemetery
Date: 12/30/2001
20c. Location - City or Town, State: Galena, Maryland

21. Signature of Funeral Service Licensee: Mary B Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress St., Millington, MD 21651

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial infarction — hours
Due to (or as a consequence of):
b. Atherosclerotic coronary artery disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D45158
29d. Data signed *(Month, Day, Year)*: 12/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Mulvey 111 W. High Street, Elkton, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 2002
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42717

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David O. Brown

2. Date of Death (Month, Day, Year): December 01, 2001

3. Time of Death: 2110 M

4a. Facility Name (If not institution, give street and number): The Kent & Queen Anne's Hospital, Inc.

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 064-22-4296

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 8, 1928

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.

10b. County: Kent

10c. City, Town or Location: Rock Hall

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5859 North Main Street

10f. Zip Code: 21661

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales / Management

16b. Kind of Business/Industry: Rohm and Haas Chemical Company

17. Father's Name (First, Middle, Last): B. Osmond Brown

18. Mother's Name (First, Middle, Maiden Surname): Emily Breitenstein

19a. Informant's Name/Relationship (Type, Print): Tish Brown (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5859 North Main Street Rock Hall, Md. 21661

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul's Cemetery

Date: 12/6/2001

20c. Location - City or Town, State: Earleville, Maryland

21. Signature of Funeral Service Licensee: Kirk A. Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SMALL CELL LUNG CANCER — 6 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John C Seymour MD

29c. License number: D-0013824

29d. Date signed (Month, Day, Year): 12-3-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. John C. Seymour 122 Speer Road Suite 5 Chestertown, Md. 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 05 2001

32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42718

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ADA BERG

2. Date of Death: Month Dec Day 21 Year 2001

3. Time of Death: 845 pm

4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-03-5341

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/22/1912

9. Birthplace (State or Foreign Country): WASHINGTON, D.C.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6121 MONTROSE ROAD

10f. Zip Code: 20852

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): MORRIS MALICKSON

18. Mother's Name (First, Middle, Maiden Surname): LENA GOLDBLATT

19a. Informant's Name/Relationship (Type, Print): CAROL ANN HECHT/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3746 THOMAS POINT ROAD, ANNAPOLIS, MARYLAND 21403

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BETH SHOLOM CONGR CEMTRY

Date: DEC 23, 2001

20c. Location - City or Town, State: CAPITOL HEIGHTS, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. acute cardio - pulmonary arrest

Due to (or as a consequence of): b. Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Pneumonia

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

anemia gait disorder

Chronic cerebral ischemia

dysphagia osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Consult Attorney

29c. License number: D:44907

29d. Date signed (Month, Day, Year): Dec 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Consuelo Alonso MD 6105 Montrose Road Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Berg, Ada

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42719

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLOTTE D. BERGER
2. Date of Death Month / Day / Year: DECEMBER 21, 2001
3. Time of Death: 7:00AM
4a. Facility Name *(If not institution, give street end number)*: HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-44-5252
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11/26/1908
9. Birthplace *(State or Foreign Country)*: POLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6121 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OWNER
16b. Kind of Business/Industry: GROCERY
17. Father's Name *(First, Middle, Last)*: ISAAC DONIGER
18. Mother's Name *(First, Middle, Maiden Surname)*: RIVKA ROGALSKY
19a. Interment's Name/Relationship *(Type, Print)*: ALAN BERGER/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10040 ORMOND ROAD, POTOMAC, MARYLAND 20854
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: B'NAI ISRAEL CONG CEMTRY — Date: DEC 23, 2001
20c. Location - City or Town, State: OXON HILL, MARYLAND
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. GASTRO-INTESTINAL BLEEDING
Due to (or as a consequence of):
b. UNKNOWN CAUSE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: GENERALIZED ATHEROSCLEROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D18084
29d. Date signed *(Month, Day, Year)*: DECEMBER 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42720

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William L. Berlinsky
2. Date of Death Month Day Year: December 23, 2001
3. Time of Death: 5:35 AM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-07-0615
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 17, 1912
9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10501 Parkwood Drive
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Western Union

17. Father's Name *(First, Middle, Last)*: Lee Abe Berlinsky
18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Larry

19a. Informant's Name/Relationship *(Type, Print)*: Arline B. Berlinsky/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10501 Parkwood Drive, Kensington, MD 20895

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery — Date: Dec 27, 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: G P Bailey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Rupture Thorasic Aortic Aneurism — 12 hours
Due to (or as a consequence of):
b. Thorasic Aortic Aneurism — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Hypercholesterol; Abdominal Aortic Aneurism , Status Post Repair

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Steven M. Schwartz
29c. License number: DS1113
29d. Date signed *(Month, Day, Year)*: 12/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven M. Schwartz, MD 10400 Connecticut Avenue, #606, Kensington, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 24 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

BERLINSKY, WILLIAM, L. 12/23/01 5:35 AM

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42721

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Basil Berovetz

2. Date of Death: Month: December Day: 22, Year: 2001

3. Time of Death: 4:00AM

4a. Facility Name (If not institution, give street and number): Advantis Nursing & Rehab

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-46-7902

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 30, 1912

9. Birthplace (State or Foreign Country): Ukraine

Usual Residence of Decedent

10e. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5 Twig Place

10f. Zip Code: 20905

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Body Repairman

16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Theodore Berovetz

18. Mother's Name (First, Middle, Maiden Surname): Maria Francuh

19a. Informant's Name/Relationship (Type, Print): Halina Berovetz /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Twig Place; Silver Spring, Maryland 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Andrews Cemetery

Date: 12/27/01

20c. Location - City or Town, State: South Boundbrook, N.J.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home Inc. 11800 New Hampshire Ave. Silver Spring, MD. 20904

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Aspiration Pneumonia.	12 days.
Due to (or as a consequence of): b.	Impaired Gag Reflex	Many yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Multi-Infarct Dementia	Many yrs
Due to (or as a consequence of): d.	Atrial Fibrillation	Many yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Chronic Obstructive Pulmonary Disease, Small Sacral Pressure Sore.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

26a. Date of Injury (Month, Day Year)

26b. Time of Injury M

26c. Injury at Work? 1☐ Yes 2☐ No

26d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D31001

29d. Date signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart J. Turkewitz, MD. 7500 Greenway Cntr. Dr. #430 Greenbelt, MD 20770.

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

6F

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42722

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM D. BLINKHORN
2. Date of Death (Month, Day, Year): December 22, 2001
3. Time of Death: 12:13 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Daeth: MONTGOMERY

Funeral Director

5. Social Security Number: 578-22-3589
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 27, 1924
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Boyds
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20601 Bucklodge Road
10f. Zip Code: 20841
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No WWII If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Coordinator
16b. Kind of Business/Industry: Construction

17. Father's Neme (First, Middle, Last): Joseph Blinkhorn
18. Mother's Name (First, Middle, Maiden Surname): Amelia Craig

19e. Informent's Neme/Reletionship (Type, Print): Elizabeth J. Blinkhorn/Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20601 Bucklodge Road, Boyds, Maryland 20841

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Montgomery Crematorium, Inc.
Date: December 27, 2001
20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00198
22. Name end Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enterine diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line. (Approximete Interval Between Onset end Daath)

Immediate Cause (Final disease or condition resulting in deeth)
a. Acute Myocardial Infarction — Minutes

Due to (or es e consequence of):
b. Coronary Artery Disease — Years

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Daeth (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) end manner steted.

29b. Signature and title of certifier: [signature] MD
29c. License number: D33261
29d. Date signed (Month, Day, Year): December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Dooley, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Dey, Year): DEC 26 2001
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 42723
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Henry BREGMAN	December 23, 2001	6:25 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
160-26-0588	1☐M 2☐F	68 Yrs.			July 10, 1933	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14514 Homecrest Road #L-24	20906	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1956-1962	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Pharmacist	Pharmacy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Bregman	Rachel Esther Marcus

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paul Ethridge, Friend	4205 Great Oak Road, Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Lebanon Cemetery	12/24/01	Adelphi, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Torchinsky Hebrew Funeral Home, Inc.
254 Carroll Street, NW, Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. Carcinoma of Pancreas

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
a. <12 hrs
b. ~ 4 days

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ronald A. Uscinski

29c. License number: D19859

29d. Date signed (Month, Day, Year): 27 Dec 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1811 Prince Phillip Drive, Olney, MD 20832 Ronald Uscinski, M.D.

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Deneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42724

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Tima of Daath
ESTHER V. BROOKS	December 24, 2001	11:55 A M

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Death
Brooke Grove Nursing Center	Sandy Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplace (Stata or Foraign Country)
176-24-2339	1☐M 2☒F	89 Yrs.			July 7, 1912	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Montgomery	Germantown	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
12709 Found Stone Road #102	20876	United States

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.)	14. Race - Amarican Indian, Black, Whita, atc.
1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Homemaker	Own Home

17. Fathar's Nama (First, Middle, Last)	18. Mother's Nema (First, Middle, Maiden Surnama)
John F. Kuntz	Bertha London

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20876
Shirley Ladd/Daughter	12709 Found Stone Road #102, Germantown, Maryland

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetery, crematory or othar place)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Removat from State 4☐Donation 5☐Other (Specify)	Church of Christ Cemetery	December 28, 2001	Troutville, Pennsylvania

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
M00198	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not antar the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only ona ceuse on each line.

		Approximate Intarval Between Onsat and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiomyopathy Congestive	Terminal
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last	Due to (or as a consequence of): b. Arteriosclerotic Cardiovascular Disease	Years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Dete of delivery Month Day Year
1☐Yas 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying cause givan in Part I.

23a. Did tobacco use contributa to the ceusa of deeth? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Wera autopsy findings availabla prior to complation of causa of death?
1☐Yes 2☒No	1☐Yas 2☐No

25. Was case referred to medical examiner?	26. Placa of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Homa 5☐Rasidance 6☐Other (Specify)

27. Mannar of Deeth	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yas 2☐No	

28e. Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify)	28f. Location (Straet and Numbar or Rural Routa Numbar, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurrad at tha tima, data and place, and dua to tha ceusa(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signad (Month, Day, Year)
Donald R. Lewis	D06406	December 24, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Donald R. Lewis, M.D. 4000 Route 108, Olney, Maryland 20832

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
DEC 28 2001	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

6

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42725

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROSE M. BUDD
2. Date of Death Month Day Year: DEC. 19, 2001
3. Time of Death: 5:00 PM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-46-3691
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 52 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar 13, 1949
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 19914 Zion Road #92
10f. Zip Code: 20830
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cashier
16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Joseph Riggs
18. Mother's Name *(First, Middle, Meiden Surneme)*: Minerva Ellison

19a. Informant's Name/Relationship *(Type, Print)*: Michelle Reid / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4201 Jones Bridge Rd Bethesda, MD 20814

20e. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removet from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt Zion U.M.C.
Date: 12/27/2001
20c. Location - City or Town, State: Brookville, MD

21. Signature of Funeral Service Licensee: Ernest R. Snowden
22. Name and Address of Facility: Snowden Funeral Home P.A. 246 N Washington St, Rockville, MD20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finet diseese or condition resulting in deeth):
a. Metastatic Uterine Cancer — 2 months

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Lest
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetet deeth 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other *(specify)* 9☐Unknown
23d. Dete of delivery Month Day Year

Part II. **Dther significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was en autopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sethi
29c. License number: D 52767
29d. Date signed *(Month, Day, Year)*: December 20, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Harminder Sethi, M.D. 50 W. Edmonston Dr., Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 26 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42726

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Thomas J. Burke
2. Dete of Deeth — Month: December Day: 24 Year: 2001
3. Time of Death: 5:27 AM
4a. Facility Name (If not institution, give street end number): Villa Rosa Home
4b. City, Town, or Location of Death: Mitchellville
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 719-01-2964
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. lest birthday): 88 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): Apr 28, 1913
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8930 Hilton Hill Drive
10f. Zip Code: 20706
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Car Repairman
16b. Kind of Business/Industry: Railroad

17. Fether's Neme (First, Middle, Last): Thomas Joseph Burke
18. Mother's Neme (First, Middle, Maiden Surneme): Eugenia Lee Williams

19e. Informent's Neme/Reletionship (Type, Print): Concetta Burke / Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 8930 Hilton Hill Drive, Lanham, MD 20706

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca): Fort Lincoln Cemetery
Dete: Dec 28, 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signeture of Funerel Service Licensee: John E. Parker
22. Neme end Address of Feciility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel diaeese or condition resulting in death): e. Atherosclerotic Heart Disease — many years

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Atrial Fibrillation, Multi-Infarct Dementia

Abdominal Aortic Aneurysm

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy pertormed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Covering Physician
29c. License number: D 31001
29d. Date signed (Month, Day, Year): December 24, 2001

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Stuart J. Turkewitz, MD 7500 Greenway Center Drive, Suite 430, Greenbelt, MD

State Registrar

31. Dete filed (Month, Dey, Year): DEC 26 2001
32. Registrer's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42727

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion Elaine Burns

2. Date of Death (Month, Day, Year): December 24, 2001

3. Time of Death: 4:10P M

4a. Facility Name (If not institution, give street and number): 9707 Old Georgetown Road

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 084-05-0691

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August4,1912

9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9707 Old Georgetown Road

10f. Zip Code: 20814

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Zucker

18. Mother's Name (First, Middle, Maiden Surname): Fanny Perlman

19a. Informant's Name/Relationship (Type, Print): Richard W. Burns/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11804 Hayfield Ct. Potomac, Maryland 20859

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metropolitan Crematory

Date: December26, 2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: James E. [illegible]

22. Name and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 20007

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident — 14 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Liva birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown

23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery disease, HBP, Diabetes

23a. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lee R. Pennington, MD

29c. License number: DZ1115

29d. Date signed (Month, Day, Year): Dec. 26,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee R. Pennington,M.D. 10215 Fernwood Road, #100 Bethesda,Md.20817-1106

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-7278-033

KAY
BECKWITCH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42728

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kay Frances Beckwith

2. Date of Death Month Day Year: DECEMBER 23, 2001

3. Time of Death: 1:12P.M.

4a. Facility Name (If not institution, give street and number): 7521 RIVERDALE ROAD

4b. City, Town, or Location of Death: HYATTSVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 243-66-6174

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 12, 1942

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: New Carrollton

10d. Inside City Limits: ☒1 Yes 2☐ No

10e. Street and Number: 7521 Riverdale Road, Apt. 1964

10f. Zip Code: 20784

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Data Processor

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Rufus Beckwith, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Henrietta Moore

19a. Informant's Name/Relationship (Type, Print): Linda Faye Jeffreys/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2001 Barwell Road, Raleigh, NC 27610

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Wakefield Baptist Church Cemetery

Date: 12/29/01

20c. Location - City or Town, State: Zebulon, NC 27597

21. Signature of Funeral Service Licensee: Dennis Robinson

22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine Street, Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie McGrath MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANNE A. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #10a,c, 12/28/01, EMW, Montg.Co *Certificate of Death* Reg. No. 2001 42729

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ALBERT R. BARCILON	DECEMBER 23, 2001	1:35P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARINER HEALTH CARE	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
022-34-6340	1☒M 2☐F	65 Yrs.			11/22/1936	EGYPT

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.		WASHINGTON, ~~D.C.~~	☒1 Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4101 CATHEDRAL AVE, NW #603	20016	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	SALES MANAGER	FOOD COMPANY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
NESSIM ROBERT BARCILON	SARAH MARQUESTE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HELENE BARCILON/WIFE	4101 CATHEDRAL AVE, NW #603, WASHINGTON, DC 20016

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT. LEBANON CEMETERY	DECEMBER 26, 2001	ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. BLADDER CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequenca of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditiona** contributing to death but not rasulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ Elliot R. Goldstein	D0558/	12/24/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. ELLIOT R. GOLDSTEIN 9410 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20814

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42730

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Randolph Busch, Sr.	December 15 2001	9:05 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
899 Holly Drive West	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-16-7808	1 [X] M 2 [ ] F	75 Yrs.			September 24, 1926	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
899 Holly Drive West	21401	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1946	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Owner	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Linwood Busch	Agnes Lowman

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan Busch/wife	899 Holly Drive West Annapolis, MD 21401

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Baltimore Crematory	12/17/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donald A. Taylor

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. end stage renal disease	1 wk
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. type II diabetes	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnency: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

gangrene of foot

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D38158	12/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lisa A DiMarco, 2003 Medical Parkway, Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 19 2001	Penny P Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42731

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert M. Brandstetter
2. Date of Death Month Day Year: December 14, 2001
3. Time of Death: 2:40 AM
4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent & Rehabilitation Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-20-2646
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 80 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov.5,1921
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Gambrills
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2291 Dairyfarm Road
10f. Zip Code: 21054
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12; Collega (1-4or 5+): 2
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Director
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Josef Brandstetter
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Garrett

19a. Informent's Neme/Reletionship *(Type, Print)*: Albert M. Brandstetter, Jr.(son)
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2291 Dairyfarm Road, Gambrills, Md. 21054

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Cedar Hill Cemetery
Dete: 12-18-01
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complicetions that caused the deth. Do not anter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert tailure. List only one causa on aach lina.

Approximeta Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deth):
a. Aspiration Pneumonia — 1 day
Due to (or es e consequance of):
b. Dysphagia
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part II. **Other signifficant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of daeth? 1 [ ] Yes 2 [X] No

25. Wes cesa referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At homa, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceusa(s) and manner es stated. 2 [ ] **Medical Examiner**: On the basis of axamination end/or Invastigetion, in my opinion, deeth occurred et the time, date end place, and dua to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature] MD
29c. License number: D38958
29d. Date signed *(Month, Dey, Year)*: 12/14/2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Dafeet Singh Sidhu 1413 Annapolis Road #106 Odenton MD 21113

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 17 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42732

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Betty Jean Keen Cole	December 23 2001	1530 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
772 West Old Philadelphia Road	North East	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
231-56-5378	1☐M 2☒F	64 Yrs.			OCT 27, 1937	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	North East	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
772 West Old Philadelphia Road	21901	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Homemaker	In Her Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard Vesper Keen	Lou Verne Adams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ulise L. Cole/Husband	772 West Old Philadelphia Road North East, Maryland 21901

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	West Nottingham Presbyterian Cemetery	December 28, 2001	Colora, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald S. Hicks	Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC OBSTRUCTIVE LUNG DISEASE	> 5 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Sudhanjani MD	D45344	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH DHANJANI, MD, 622 S. UNION AVE, HAVRE DE GRACE, MD 21078

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Pamela B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42733

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annette M. Chandler

2. Date of Death (Month, Day, Year): DECEMBER 24, 2001

3. Time of Death: 4:03 AM

4a. Facility Name (If not institution, give street and number): Doctors Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 248-70-4083

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-18-1941

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 16705 Dorchester Place

10f. Zip Code: 20772

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educational Assistant

18b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Murkeson Smith

18. Mother's Name (First, Middle, Maiden Surname): Geneva Smith

19e. Informant's Name/Relationship (Type, Print): Ernest Chandler/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16705 Dorchester Place, Upper Marlboro, MD 20772

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ressurection

Date: 12-29-01

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: ▶ K. D. Marshall

22. Name and Address of Facility: J. B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 20785

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

CHANDLER, Annette

CR

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EDEMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ACUTE MYOCARDIAL INFARCTION — 1 HOUR

Due to (or as a consequence of):

c. HYPERTENSIVE ARTERIOSCLEROTIC — 10 YRS

Due to (or as a consequence of):

d. CARDIOVASCULAR DISEASE

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ James C. Warn MD

29c. License number: D16197

29d. Date signed (Month, Day, Year): 12-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES C. WARN MD - 9326 LANHAM-SEVERN RD. LANHAM MD

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

DEC 5 8 500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42734

Carroll, Charles

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Charles H. Carroll, Sr.	December 27, 2001	0702 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578 16 3577	1☒ M 2☐ F	81 Yrs.			Jan. 26, 1920	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Queen Anne	Queenstown	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
124 Olde Point Lane	21658	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 44/46	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12	0	Electrician-Mechanic	Palmer Ford

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frederick Carroll	Ella Rebecca Whitford

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Diane Carroll-Cobb Daughter	8185 E. Mesquite Ridge Circle Tucson AZ 85710

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lakemont Memorial Gardens	Jan. 3, 2002	Davidsonville MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael L Bgln	Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular accident	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Encephalopathy	
	Due to (or as a consequence of): c. Hypertensive crisis	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure
Colon cancer

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Lakshmi Vaidyanathan, MD	D0057749	12-27-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lakshmi Vaidyanathan M.D. Memorial Hospital Easton Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Penny B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(10) 11a

DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42735

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
RICHARD	CAMPBELL	DEC. 19, 2001	11:04 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-36-7903	1 [X] M 2 [ ] F	74 Yrs.			11-08-1927	Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DC		Washington	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
412-10th St. N.E.	20002	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Nurse	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard D. Campbell	Edna Woody

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ginger Wright/ Granddaughter	4029-23 Parkway, Temple Hills, MD 20748

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Harmony Memorial Park	12-28-2001	Landover, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. D. Marshall	J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, Maryland 20785

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ventricular Tachycardia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Seizure Disorder	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	MD32286	12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Cecilia M Hammond, MD 2100 W Pennsylvania Ave NW Washington DC 20037

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Barbara G. Franks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

DEC 2 7 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42736

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stanley Edward Caldeira
2. Date of Death (Month, Day, Year): December 13, 2001
3. Time of Death: 1543 M
4a. Facility Name (If not institution, give street and number): Kent & Queen Anne's Hospital, Inc.
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 451-36-8356
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 12, 1928
9. Birthplace (State or Foreign Country): Peru

Usual Residence of Decedent

10a. State: Md
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 203 Waldo Drive
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Export Sales
16b. Kind of Business/Industry: J.M. Huber Corp.

17. Father's Name (First, Middle, Last): Manuel D. Caldeira
18. Mother's Name (First, Middle, Maiden Surname): Erika Kessel

19a. Informant's Name/Relationship (Type, Print): Nancy Caldeira (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 203 Waldo Drive Chestertown, Md. 21620

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ches. Cremation Cntr. Date: 12/15/2001
20c. Location - City or Town, State: Stevensville, Md.

21. Signature of Funeral Service Licensee: Keith J. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Merkel Cell Carcinoma with metastases
Approximate Interval Between Onset and Death: 15 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Interstitial Fibrosis

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan K. Ross MD
29c. License number: D17036
29d. Date signed (Month, Day, Year): 12/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan K. Ross MD 516 Washington Ave Chestertown Md 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 18 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42737

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Eleanora F. Campbell
2. Dete of Death (Month, Dey, Yeer): December 7, 2001
3. Time of Death: 12:10AM
4e. Facility Name (If not institution, give street and number): Chestertown Nursing & Rehab. Center
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 160-09-7813
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 89 Yrs. (If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.)
8. Dete of Birth (Month, Dey, Yeer): Aug. 27, 1912
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. Stete: Md
10b. County: Kent
10c. City, Town or Location: Rock Hall
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 7184 Rock Hall Road
10f. Zip Code: 21661
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐Yes 2☒No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Neme (First, Middle, Last): George Fiore
18. Mother's Neme (First, Middle, Maiden Surneme): Philomena Mottola
19a. Informant's Neme/Reletionship (Type, Print): Patricia A. Campbell (Daughter)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 7184 Rock Hall Road Rock Hall, Md. 21661
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other piece): St. Paul's Cemetery
Dete: 12/11/01
20c. Location - City or Town, State: Chestertown, Md.
21. Signeture of Funerel Service Licensee: [signature]
22. Neme and Address of Fecility: Bellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road Chestertown, Md. 21620

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23e. Pert1. Enter the diseese or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth)
a. Aspiration Pneumonia — 6days
Due to (or es e consequence of):
b. Alzhoimers
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.
Pul fibrosis/HxSVT/GERD/HxGI Bleeds
Hx Transitional Cell CA of Bladder/COPD
Osteoporosis

23b. Did tobacco use contributa to the causa of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en eutopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes cese referred to medicel examiner? 1☐Yes 2☒No
26. Piece of Death (Check only one): Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐Medical Examiner: On the basis of examination and/or Investigetion, in my opinion, death occurred at the time, date end piece, snd due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D50996
29d. Dete signed (Month, Dey, Yeer): 12/10/01

30. Neme and sddress of person who completed cause of death (Item 23a) (Type, Print): Dr. Neil Stoddard 100 Brown Street Chestertown, Md. 21620

State Registrar

31. Dete filed (Month, Day, Year): DEC 11 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42738

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edna Margaret Chase
2. Date of Death Month: Dec Day: 28 Year: 2001
3. Time of Death: 1205 PM
4a. Facility Name *(If not institution, give street and number)*: Solomons Nursing Center
4b. City, Town, or Location of Death: Solomons
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 218 14 8625
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: May 25 1924
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Rasidence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Lusby
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11765 H.G. Tueman Road
10f. Zip Code: 20657
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Nevar Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Detas:
13. Was Decedent ot Hispanic Origin? (Specify Yas or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind ot Business/Industry: own home

17. Father's Nema *(First, Middle, Last)*: Charles Fisher
18. Mothar's Nema *(First, Middle, Maiden Surname)*: Jannie Margaret Webb

19a. Intormant's Name/Reletionship *(Type, Print)*: Joyce Rhynes - daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1888 Lusby Maryland 20657

20a. Method ot Disposition: 1☐ Burial 2☒ Crametion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place ot Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Funeral Service
Date: Dec 30 2001
20c. Location - City or Town, State: Alexandria Virginia

21. Signeture of Funeral Service Licensee: ▶ B Rausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the daeth. Do not enter the mode ot dying, such as cerdiac or respiratory errest, shock, or haart failura. List only ona cause on aach lina.

Approximate Interval Between Onset and Death

Immedieta Cause (Final disease or condition resulting in deeth)
a. Chronic obstructive Lung disease — more than 2 Years

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Lung Tumor Possibly Malignant
Renal Stones

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion ot ceuse ot death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yas 2☒ No
26. Plece ot Death *(Check only one)*
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time ot Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place ot Injury - At home, tarm, street, tactory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.
29b. Signeture end title of certifier: ▶ Geyan C. Surana
29c. Licensa number: D 50653
29d. Date signed *(Month, Day, Year)*: 12-28-2001.
30. Nama and address of person who completed ceuse ot death (Item 23a) (Type, Print): GYAN - C - SURANA 5851 Deale Churchton Road Deale MD 20751.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 2002
32. Registrar's Signatura: ▶ Penna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42739

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Lee Craig

2. Date of Death (Month, Day, Year): December 28, 2001

3. Time of Death: 0520

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Camp Springs

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 219 48 5302

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 14, 1948

9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residance of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6289 South Osborne Road

10f. Zip Code: 20772

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Nevar Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - Amaricen Indian, Black, White, atc. Specify: white

15. Decedent's Educetion (Specify only highast grada completed): Elementary/Secondary (0-12): 12 — Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): beautician

16b. Kind of Businass/Industry: cosmetology

17. Father's Name (First, Middle, Last): Samuel Richard Walker

18. Mothar's Nama (First, Middle, Maiden Sumame): Georgiana Bernice Kreuter

19a. Informant's Name/Ralationship (Type, Print): Barton R. Craig

19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): same as 10a-f above

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Metropolitan Crematory

Dete: 12-31-01

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ William R. Jones

22. Nama and Addrass of Fecility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications thet ceused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Batween Onset and Death

Immedieta Cause (Final disaasa or condition rasulting in death): a. Arteriosclerotic Hypertensive Heart Disease

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immadieta ceusa. Entar Underlying Cause (Disaasa or injury that initiated avents rasulting in death) Last:

b.

Dua to (or as a consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other signficant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Ware autopsy findings availabla prior to complation of ceuse of death? 1☐ Yes 2☐ No

25. Was cesa rafarrad to medicel examiner? 1☑ Yes 2☐ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatiant 2☑ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)

27. Manner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. 2☑ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier: ▶ Salvador Sylvester, MD

29c. License number: H0055927

29d. Data signed (Month, Day, Year): December 31, 2001

30. Nama and address of person who completed ceusa of daath (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 02 2002

32. Registrar's Signatura: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42740

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Enzo C. Conti	December 23 2001	11:20 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-64-5022	1☒M 2☐F	69 Yrs.			July 31, 1932	Italy

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Bethesda	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4521 East West Highway	20814	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: Unknown	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Chef	Culinary

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lucio Conti	Santina Bianchi

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Martha R. Conti/ Wife	4521 East West Highway Bethesda, MD 20814

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Geo. Wash. University Medical Center	December 26 2001	Washington, D.C.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acute renal failure	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sacral decubitus

Diabetes Mellitus

Cerebral Vascular Accident

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)	
1☒	**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐	**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] / MD	D0057124	12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Detruong Bao, M.D.	13219 Executive Park Terrace Germantown, MD 20874

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Enzo Conti, 12/23/01 11:20AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42741

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN E. COUSINS
2. Date of Death (Month, Day, Year): DEC. 21, 2001
3. Time of Death: 3:40 AM
4a. Facility Name (If not institution, give street and number): FAIRLAND NURSING AND REHAB. CTR.
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-32-4425
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 25, 1927
9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8617 PINEY BRANCH RD.
10f. Zip Code: 20901
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name (First, Middle, Last): CHRISTOPHER COUSINS SR.
18. Mother's Name (First, Middle, Maiden Surname): HELEN R. REILLY

19a. Informant's Name/Relationship (Type, Print): CHRISTOPHER COUSINS JR./BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 EASLEY ST., SILVER SPRING, MD. 20910

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY
Date: 12/27/01
20c. Location - City or Town, State: SILVER SPRING, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers
M00091
22. Name and Address of Facility: 5801 CLEVELAND AVE.,RIVERDALE,MD. CHAMBERS FUNERAL HOME & CREMATORIUM,P.A. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC SQUAMOUS CELL LUNG CANCER — > 1 YR.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION, ANEMIA, HYPONATREMIA

URINARY RETENTION

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: [illegible] MD
29c. License number: D31001
29d. Date signed (Month, Day, Year): DEC. 21, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): STUART J. TURKEWITZ, M.D. 7500 GREENWAY CTR. DR. #430, GREENBELT, MD. 20770

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

MERY

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

M41

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42742

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
FRANK G. CABBLE	DEC. 20, 2001	7:10 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SUBURBAN HOSPITAL	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
106-22-6020	1[X] M 2[ ] F	73 Yrs.			DEC. 28, 1927	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	MONTGOMERY	KENSINGTON	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3616 LITTLEDALE RD.	20895	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: WWII	1[ ] Yes 2[X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	OWNER	MANUFACTURING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GILBERT CABBLE	IDA BENKIE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CLAUDIA C. BURWELL/DAUGHTER	6208 30th ST. N.W., WASHINGTON, D.C. 20015

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	CHAMBERS CREMATORY	12-22-01	RIVERDALE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ W.H. Chambers M00091	5801 CLEVELAND AVE.,RIVERDALE,MD. CHAMBERS FUNERAL HOME & CREMATORIUM,P.A. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	4 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D37891	DEC. 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. ARAJVANSHI, M.D. 121 CONGRESSIONAL LN. #409, ROCKVILLE, MD. 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Cabble, Frank 12/20 0716

9+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42743

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Nancy Coleman Cantrel	December 24, 2001	11:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6602 Tusculum Road	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-38-4663	1☐ M 2☒ F	72 Yrs.			January 11, 1929	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Bethesda	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6602 Tusculum Road	20817	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Henry Coleman	Estelle Adelaide Drinkard

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Francis J. Cantrel/Husband	6602 Tusculum Road, Bethesda, Maryland 20817

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Montgomery Crematorium	Dec. 27, 2001	Bethesda, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M00198	Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Breast Cancer	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	MD 11506	December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick P. Smith, M.D. 5401 Western Avenue, N.W. Washington, D.C. 20015

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42744

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur Duncan Cashell Jr
2. Date of Death (Month, Day, Year): Dec 22 2001
3. Time of Death: 1830
4a. Facility Name (If not Institution, give street and number): 10011 REDDICK DRIVE
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578 01 1416
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 19, 1917
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 10011 REDDICK DRIVE
10f. Zip Code: 20901
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INSTALLER
16b. Kind of Business/Industry: HEATING AND AIR COMPANY

17. Father's Name (First, Middle, Last): ARTHUR D. CASHELL, SR.
18. Mother's Name (First, Middle, Maiden Surname): MABEL BARNSLEY

19a. Informant's Name/Relationship (Type, Print): JAMES D. CASHELL, SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10011 REDDICK DRIVE, SILVER SPRING, MD. 20901

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): SALEM CEMETERY
Date: 12/27/01
20c. Location - City or Town, State: BROOKEVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASCVD — DME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD OME
29c. License number: D07426
29d. Date signed (Month, Day, Year): Dec 24 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRA N BRECHER MD OME 2101 Medical Park Dr Silver Spring MD 20902

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-7276-033

MIQUEL CASTILLO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 011802:ITEMS#23a,27,28a-f per ME G805 ss

Certificate of Death

Reg. No. 2001 42745

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Miguel Ortega Castillo

2. Date of Death (Month, Day, Year): DECEMBER 23, 2001

3. Time of Death: 10:31A.M.

4a. Facility Name (If not institution, give street and number): 3517 TOLEDO TERRACE

4b. City, Town, or Location of Death: HYATTSVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: none

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 23 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept.29,1978

9. Birthplace (State or Foreign Country): Mexico

Usual Residence of Decedent

10a. State: Md

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6604 Belcrest Road #L5

10f. Zip Code: 20782

10g. Citizen of What Country?: Mexico

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒Yes 2☐No Specify: Mexican

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Junk Yard

17. Father's Name (First, Middle, Last): Jorgue Ortega

18. Mother's Name (First, Middle, Maiden Surname): Maria Elena Castillo Paredes

19a. Informant's Name/Relationship (Type, Print): Micaela Ortega Castillo/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782: 6604 Belcrest Rd.#L5 Hyattsville,Md

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Xalapa,Vericruz

Date: 1/03/02

20c. Location - City or Town, State: Veracruz,Mexico

21. Signature of Funeral Service Licensee: Philip D Rinaldi

22. Name and Address of Facility: Philip D.Rinaldi Funeral Service 9241 Columbia Blvd,Silver Spring,Md20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death) e. CARBON MONOXIDE INTOXICATION

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Menner of Death: 1☐Netural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Date of Injury (Month, Day Year) Found: 12-23-01

28b. Time of Injury Found: 10:"10a M

28c. Injury at Work? 1☒Yes 2☐No

28d. Describe how injury occurred: Subject inhaled automobile exhaust fumes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found in parked auto

28f. Location (Street and Number or Rural Route Number, City or Town, State): 3517 Toledo Terrace, Hyattsville, MD

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as steted. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Pestaner M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 24,2001

30. Name and address of parson who completed cause ot death (Item 23e) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42746

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIE K. CHYTILO
2. Date of Death (Month, Day, Year): DECEMBER 26, 2001
3. Time of Death: 6:45 AM
4a. Facility Name *(If not institution, give street and number)*: SHARON NURSING HOME
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-32-1294
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 20, 1932
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18035 O'Hara Circle
10f. Zip Code: 20832
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Executive Secretary
16b. Kind of Business/Industry: Retail Stores

17. Father's Name *(First, Middle, Last)*: Clifton W. Kramer
18. Mother's Name *(First, Middle, Meiden Surneme)*: Helen Griffith

19a. Informant's Name/Relationship *(Type, Print)*: Lauretta K. Morgan / Niece
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 18035 O'Hara Circle, Olney, Maryland 20832

20e. Method of Disposition: 1☐ Buriat 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Ptace of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory | Date: 12/27/01
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Feciility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused tha death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heert failure. List only one ceuse on aach line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in deeth):
a. ASPIRATION PNEUMONIA — 3 DAYS
Due to (or as e consequence of):
b. DYSPHAGIA
Due to (or as a consequence of):
Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. ADVANCED SENILE DEMENTIA
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medicet examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Coutd not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptace of Injury - At home, farm, atreet, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end manner stated.
29b. Signeture and title of certifier: ▶ TE Howe MD
29c. License number: D33700
29d. Date signed *(Month, Day, Year)*: DECEMBER 26, 2001
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE, MD 154 N. ARTIZAN STREET, WILLIAMSPORT, MD 21713

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 28 2001
32. Registrar's Signature: ▶ Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42747

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Yaar	3. Time of Death
MARY MARTHA COLEMAN	DEC. 24, 2001	6:00 A M

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Death
CASEY HOUSE	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sax	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-42-7965	1☐ M 2☒ F	67 Yrs.			AUG. 1, 1934	WASH. D.C.

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	MONTGOMERY	ROCKVILLE	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
14317 GAINES AVE.	20853	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Raca - American Indian, Black, Whita, etc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		HOUSEWIFE	HOME

17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
STANLEY E. CONDOLON	BEATRICE DOBBINS

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KEVIN COLEMAN/SON	14317 GAINES AVE., ROCKVILLE, MD. 20853

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cremetion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	GATE OF HEAVEN CEM.	12-28-2001	SILVER SPRING, MD.

21. Signatura of Funaral Service Licansaa	22. Nama and Addrass of Facility
▶ W.W. Chambers M00091	5801 CLEVELAND AVE.,RIVERDALE,MD. CHAMBERS FUNERAL HOME & CREMATORIUM,P.A. 20737

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or haart failura. List only one causa on aach line.

		Approximate Intarval Batwean Onsat and Death
Immediete Cause (Final disaasa or condition resulting in death)	a. RECURRENT OVARIAN CARCINOMA	
Sequantially list conditions, if any, laading to immediete cause. Entar Underlying Cause (Diseasa or injury that initiated avents rasulting in death) Last	Due to (or as a consequance of): b.	
	Due to (or as a consequence of): c.	
	Dua to (or as a consequance of): d.	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yas, outcoma of pregnancy	23d. Data of dalivary Month / Day / Year
1☐ Yas 2☒ No 9☐ Unknown	1☐ Liva birth 2☐ Fetal daath 3☐ Ectopic pregnancy 4☐ Pragnant at tima of daath 5☐ Other (specify) 9☐ Unknown	

Part II. **Dther significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

23a. Did tobacco use contribute to tha causa of daath?	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to complation of causa of daath?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was casa rafarred to madical examinar?	28. Placa of Daath (Check only one)	
1☐ Yas 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Rasidence 6☒ Othar (Specify) HOSPICE

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be datarmined		M	1☐ Yes 2☐ No	
	28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one)
1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, data and placa, and due to tha causa(s) and mannar es steted.
2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurrad at tha time, data and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of cartifiar	29c. License number	29d. Data signed (Month, Day, Year)
▶	D42452	DEC. 24, 2001

30. Nama and addrass of parson who complated causa of daath (Itam 23a) (Typa, Print)
CHITRA RAJAGOPAL, M.D., 18111 PRINCE PHILIP DR., OLNEY, MD. 20832

State Registrar

31. Data filad (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Geneva G. Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42748

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
LOUIS R. COLROSS SR.	12	23,	2001	1:35 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5600 62nd. AVE.	RIVERDALE	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
185-07-1942	1[X] M 2[ ] F	85 Yrs.			OCT. 29, 1916	PA.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	PRINCE GEORGES	RIVERDALE	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5600 62nd. AVE.	20737	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: WWII	1[ ] Yes 2[X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done dunng most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		MECHANIC	U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
RALPH COLROSS	JULIA VALENTINE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LILLIAN B. COLROSS/WIFE	5600 62nd. AVE., RIVERDALE, MD. 20737

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	GATE OF HEAVEN CEM.	12-28-2001	SILVER SPRING, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
W.W. Chambers #000091	5801 CLEVELAND AVE., RIVERDALE, MD. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC ADENOCARCINOMA COLON	YEARS
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Day / Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetel deeth 3[ ] Ectopic pregnency 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[X] Residence 8[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D24035	12 23 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EJ MAHINN 321 PRINCE GEORGE ST LAUREL MD 20707

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After the certificate has been signed by the standing physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

19+1

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42749

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert T. Catterton

2. Date of Death (Month, Dey, Year): December 11, 2001

3. Time of Death: 4:30 A.M.

4a. Facility Name (If not institution, give street and number): 173 Harwood Road

4b. City, Town, or Location of Death: Harwood

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-12-9989

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): Feb. 20,1908

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland | 10b. County: Anne Arundel | 10c. City, Town or Location: Harwood | 10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 173 Harwood Road | 10f. Zip Code: 20776 | 10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Merried 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Elliott Catterton

18. Mother's Name (First, Middle, Maiden Surneme): Mary M. Bassford

19e. Informant's Name/Relationship (Type, Print): Nancy C. Parlett/ Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): P.O. Box 224 Edgewater, Maryland 21037

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Church Cemetery

Date: 12-14-01

20c. Location - City or Town, Stete: Lothian, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)

a. Alzheimer's disease.

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: [signature]

29c. License number: D26743

29d. Dete signed (Month, Dey, Year): 12/11/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Howard D. Goldstein, M.D. 205 Ridgley Avenue Annapolis, Maryland 21401

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Dey, Year): DEC 12 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42750

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Alice Marie Childers	December 9, 2001	3:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
156 Ridgeway Circle	Arnold	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
567-28-5601	1☐M 2☒F	79 Yrs.			July 7, 1922	Washington DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
25 Southgate Avenue	21401	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	Cottege (1-4or 5+)		
	4	Interior Designer	Design

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Blair Lee Montgomery	Josephine Van Orden

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judy Lee Meade / Daughter	156 Ridgeway Circle Arnold, MD 21012

20a. Method of Disposition	20b. Ptece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1☐Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Baltimore Crematory	12/10/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Neme and Address of Facility
Bernard C. McBarker	John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Acute Myocardial Infarction	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Atherosclerosis	Years
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant condtions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☒No 3☐Probebly 4☐Unknown	
24e. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred lo medical examiner? 1☐Yes 2☒No	28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) Daughters Home

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Phyaician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Jon B. Love	D 18529 MD	December 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon B. Love, M.D. 2009 Tidewater Colony Drive Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 11 2001	Bernard C. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-7320-015

JASON DACEY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42751

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jason Kyle Dacey
2. Date of Death Month Day Year: DECEMBER 26, 2001
3. Time of Death: 5:47A.M.
4a. Facility Name *(If not Institution, give street and number)*: UNION HOSPITAL
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 214-15-2653
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 15 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: February 10, 1986
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 17 Buck Wheat Run Road
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student
16b. Kind of Business/Industry: School

17. Father's Name *(First, Middle, Last)*: James Dacey
18. Mother's Name *(First, Middle, Maiden Surname)*: Debra Lynn Fields

19a. Informant's Name/Relationship *(Type, Print)*: James & Debra Dacey/ Parents
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17 Buck Wheat Run Road, North East, Maryland 21901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rose Bank Cemetery
Date: December 30, 2001
20c. Location - City or Town, State: Calvert, Maryland

21. Signature of Funeral Service Licensee: Robert E. Crouch
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY LYMPHANGIOMATOSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: O.C.M.E.
29d. Data signed *(Month, Day, Year)*: DECEMBER 27, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. ripple M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date Filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42752

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stanley O. Dunaway

2. Date of Death Month: Dec. Day: 24 Year: 2001

3. Time of Death: 2:10 P.M

4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 105 03 6272

8. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 3, 1913

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 11814 Galaxy Lane

10f. Zip Code: 20715

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Clothing Store

17. Father's Name (First, Middle, Last): James T. Dunaway

18. Mother's Name (First, Middle, Maiden Surname): Fannie Lee Bryant

19a. Informant's Name/Relationship (Type, Print): David Dunaway Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11814 Galaxy Lane Bowie Maryland 20715

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Huntt Crematory

Date: Dec. 26, 2001

20c. Location - City or Town, State: Waldorf Maryland

21. Signature of Funeral Service Licensee: Michael L Byler

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive CardioVascular Disease — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

b. Coronary Atherosclerosis — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Diabetes Mellitus — years

Due to (or as a consequence of):

d. Dementia — years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Prostate Carcinoma.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rakesh Monga MD

29c. License number: D 20108

29d. Date signed (Month, Day, Year): 12/26/01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 14300 Gallant Fox Lane Suite 222 Bowie Maryland 20715

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Barbara B. Franks

DHMH 17 Rev 1/2001

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42753

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William Alexander Davis	Dec. 18 2001	7:35 am M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park, MD	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-07-2563	1 M 2 F	90 Yrs.			03/13/1911	Pittsburg, PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DC		Washington	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
649 Columbia Road NW	20001	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Funeral Attendant	Dudley Funeral Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Davis	Helen Davis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sallie Davis	649 Columbia Rd., NW, Washington, DC 20001

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Rock Creek Cemetery	12/26/01	Washington, DC

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Lisa A. Henry mo1178	B.K. Henry Funeral Chapel 420 H St. NE, Washington, DC 20002

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 Unknown	1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Michael Sipe	D45660	12-28-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300, GALLANT FOX CIR, Bowie MD 20715

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Brenda B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42754

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Khanh N. Do	December 24 2001	6:55 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Community Hospital	Lanham	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-29-2213	1☐M 2☒F	71 Yrs.			March 8,1930	Vietnam

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	New Carrollton	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8513 Carrollton Parkway	20784	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Vietnamese

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1-4	Gynecologist	Medicine

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Huan Do	Bay Nguyen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Chau Hoang - Husband	8513 Carrollton Parkway New Carrollton, Maryland 20784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	12/29/2001	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald V. Borgwardt	Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PROBable acute hemorrhagic Stroke	minutes
Due to (or as a consequence of):	b. acute anterior myocardial infarction 6hrs	
Due to (or as a consequence of):	c. Colon Cancer	
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Steven Tee MD	046998	December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Tee MD 3415 HAMILTON ST HYATTSVILLE, MD 20782

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Bruce B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Do, Khanh

CK

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DHMH 17 Rev 1/2001

ORIGINAL

DEC 2 7 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42755

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Elizabeth Eloise Davis	December 19, 2001	2:38 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Community Hospital	Lanham	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
419-14-8910	1☐M 2☒F	84 Yrs.			June 13, 1917	Birmingham, AL

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Bowie	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3800 Emfield Chase Court#323	20721	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3yrs	Army Pay Specialist	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Primus Davis	Mary Carter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edythe C. Cherry/Sister	11 Sylvan Terrace NY, NY 10032

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Maryland National	12-27-2001	Laurel

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. D. Marshall	J.B. Jenkins Funeral Home 7474 Landover Rd LAndover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL INFARCTION — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MYOCARDIAL ISCHEMIA — Hours

Due to (or as a consequence of):

c. SEPTIC SHOCK — Hours

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROIDISM

SLEEP APNEA

OBSTRUCTIVE LUNG DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	MD D31069	12/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Bone MD 1100 Mercantile Lane STE 135 LARGO MD 20774

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	Brenda B. Sparks

DHMH 17 Rev 1/2001

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Elizabeth Eloise DAVIS

CR

6

ORIGINAL

DEC 2 4 2001 OSD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42756

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Floyd Walker Dowdy	Dec. 26, 2001	3:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5118 Coach Ct.	Huntingtown	Calvert Co.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-20-9615	XX 1 M 2 F	80 Yrs.			Aug. 19, 1921	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Calvert Co.	Huntingtown	1 Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5118 Coach Ct.	20639	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 XX Married 3 Widowed 4 Divorced	1 X Yes 2 No 1943 1946	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Supply Officer	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Warren Edward Dowdy	Fannie Trent

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lillian R. Dowdy (Wife)	5118 Coach Ct., Huntingtown, MD 20639

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cremetory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Lee Crematory	Dec. 27, 2001	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Lee Funeral Home Calvert, P.A. 20736 8125 Southern Maryland Blvd., Owings, MD

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on each lina.

Approximata Intarval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's disease — Due to (or as a consequence of): — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d. —

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcoma of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate cancer

23a. Did tobacco use contributa to tha causa of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Wara autopsy findings available prior to completion of causa of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yas 2 X No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 XX Residence 8 Othar (Specify)

27. Manner of Death: X 1 Natural; 2 Accident; 3 Suicide; 4 Homicida; 5 Pending investigation; 6 Could not be determined

28a. Data of Injury (Month, Day Yaar) | 28b. Tima of Injury | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) | 28f. Location (Straat and Numbar or Rural Route Numbar, City or Town, State)

29a. Certifier (Check only one): X 1 **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to tha cause(s) and mannar as stated. 2 **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Year)
Robert Schlager MD	D16823	December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT J. SCHLAGER MD 110 HOSPITAL ROAD #111, PRINCE FRED., MD 20678

10+1

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42757

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Edwin Winston Daly	December 26, 2001	12:37 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-46-4868	1☒ M 2☐ F	68 Yrs.			Nov 27, 1933	DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Kensington	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3904 Morrell Court	20895	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1956-1958	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Firefighter	DC Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Joseph Daly	Katherine Taylor

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Emilie Daly / Wife	3904 Morrell Court, Kensington, MD 20895

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Gate of Heaven Cemetery	Dec 28, 2001	Silver Spring, MD

21. Signature of Funeral Service Licensee ▶ Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Coronary Artery Disease	less than 5 years
	Due to (or as a consequence of): c. Hyperlipidemia	less than 5 years
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Wes decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant et time of deeth 5☐ Other (specify) 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Aortic Aneurysm

23e. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ MD	D 40611	December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Schneider, MD 10313 Georgia Avenue, #307, Silver Spring, MD

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	▶ Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42758

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara S. Day
2. Date of Death (Month, Day, Year): December 20, 2001
3. Time of Death: 6:45 AM
4a. Facility Name (If not institution, give street and number): Carriage Hill-Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 017-36-6523
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 24, 1918
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: D.C.
10b. County:
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5901 MacArthur Blvd., N.W.
10f. Zip Code: 20016
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wss Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rsce - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ralph F. Symonds
18. Mother's Name (First, Middle, Maiden Surneme): Barbara Walker

19s. Informant's Neme/Relationship (Type, Print): Robert W. Day/Son
19b. Msiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 7128 Grinnell Drive, Rockville, Maryland 20855

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stste 4☐ Donation 5☐ Other (Specify)
20b. Plsce of Disposition (Name of cemetery, crematory or other place): Montogmery Crematorium
Date: Dec. 23, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Desth

Immediste Cause (Final disease or condition resulting in death): a. Cardiomyopathy — 1 month
Due to (or as a consequence of): Pneumonia — 1 month
Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Csuse (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, fsctory, office building, etc. (Specify):
28f. Location (Street end Number or Rural Route Number, City or Town, Stete):

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete end ptace, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D04179
29d. Date signed (Month, Dey, Year): December 21, 2001
30. Nsme snd sddress of person who completed cause of death (Item 23a) (Type, Print): James J. Foster, M.D. 5530 Wisconsin Avenue #925, Chevy Chase, Maryland 20815

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 12

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. 10

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42759

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James C. Ditto
2. Date of Death (Month, Day, Year): December 25, 2001
3. Time of Death: 3:00 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 235-16-8282
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): Aug 13, 1920
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5818 Box Elder Court
10f. Zip Code: 21703
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Talcott Eliason Ditto
18. Mother's Name (First, Middle, Maiden Surname): Hazel Somers

19a. Interment's Name/Relationship (Type, Print): Julia Ditto / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5818 Box Elder Court, Frederick, MD 21703

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: Dec 29 2001
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: ▶ Ken R. Thomas
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMER DISEASE; Multi infarct Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joseph Ashwal MD
29c. License number: D26609
29d. Date signed (Month, Day, Year): 12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jospeh Ashwal, MD 56 Thomas Johnson Drive, Frederick, MD 21702

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: ▶ Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42760

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret T. Donnald
2. Date of Death (Month, Day, Year): December 21, 2001
3. Time of Death: 1:30 AM
4a. Facility Name *(If not institution, give street and number)*: Manor Care Potomac
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 512-18-7558
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 29, 1918
9. Birthplace *(State or Foreign Country)*: Arkansas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11501 South Glen Road
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American Indien, Black, Whita, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondery (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed
16b. Kind of Business/Industry: Bird Bander

17. Fethar's Name *(First, Middle, Last)*: Ira W. Torrence
18. Mother's Neme *(First, Middle, Maidan Surneme)*: Madge Chamberlain

19a. Informant's Name/Reletionship *(Type, Print)*: Morrill B. Donnald /Husband
19b. Meiling Address *(Street end Number or Rural Routa Number, City or Town, State, Zip Code)*: 11501 South Glen Road, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Montgomery Crematorium, Inc. | Date: Dec. 24, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signeture of Funarel Service Licensee: ▶ Ray Lee M00198
22. Name end Address of Fecility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one ceusa on eech tina.

Approximete Intervat Batween Onset end Deeth

Immedieta Cause (Finel disease or condition resulting in deeth)
e. Pneumonia — Week

Due to (or es a consequence of):
b. Coronary Artery Disease — Years

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Dua to (or as e consequance of):
c. Osteoporosis — Years

Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Deeth *(Check only ona)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the tima, date and piece, and dua to the ceuse(s) end mennar es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, and dua to the causa(s) end menner stated.

29b. Signatura and title of certifier: ▶ S G Rao
29c. Licensa number: D35792
29d. Date signed *(Month, Day, Year)*: December 21, 2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Swaroop G. Rao, M.D. 50 W. Edmonston Drive, Rockville, Maryland 20852

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 26 2001
32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42761

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lillian S. DOSIK	December 27, 2001	2:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1131 University Blvd., W. #1007	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
059-12-7618	1☐M 2☒F	82 Yrs.			May 19, 1919	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1131 University Blvd., W. #1007	20902	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Elementary School Teacher	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Isidore Spieler	Rose Greenberg

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward Abramowitz, Son	1131 University Blvd., W. #1001, Silver Spring, MD 20902

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Park Cemetery	12/28/01	Paramus, NJ

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Torchinsky Hebrew Funeral Home, Inc. 254 Carroll Street, NW, Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. gastric cancer	16 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D43083	December 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE A SOTOS, MD 9707 Medical Center Drive #300 Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	[signature]

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42762

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lovell H. Day
2. Date of Death: Month 12 Day 3 Year 01
3. Time of Death: 1:00 AM
4a. Facility Name (If not institution, give street and number): 913 Spa Road
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: AA

Funeral Director

5. Social Security Number: 212-32-5043
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10 23 35
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: AA
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 913 Spa Road
10f. Zip Code: 21401
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 3/58-3/61
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Master Barber
16b. Kind of Business/Industry: State Government

17. Father's Name (First, Middle, Last): William Day
18. Mother's Name (First, Middle, Maiden Surname): Betters

19a. Informant's Name/Relationship (Type, Print): Patsy Day - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 913 Spa Road Annapolis, MD 21401

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville
Date: 12/18/01
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Miller's Metropolitan Chapel 922 Forest Drive Annapolis, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): [illegible]
a.
Due to (or as a consequence of): Hypertension — 74 yrs.
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Obesity.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D0009453
29d. Date signed (Month, Day, Year): 12/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERROL A PHILLIPS MD 1833 A. Forest Dr. Anne. MD 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 19 2001
32. Registrar's Signature: [signature] B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42763

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Michail Dolinskij		December 14 2001	14:36 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
St. Agnes Healthcare	Baltimore City		

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-26-3342	1 ☒ M 2 ☐ F	82 Yrs.			Nov 16, 1919	Russia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Anne Arundel	Pasadena	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
248 11th St.	21122	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	2	Machinist	Maritime

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gregoriy Genadevich Dolinsky	Pelageya Nikitina

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Annemarie Dolinskij (wife)	248 11th St. Pasadena, MD. 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	Chesapeake Cremation Cntr.	12-17-01	Chester, MD.

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
[signature]	M00982	Adams Funeral & Memorial Care 1000 Bestgate Rd. Suite 201 Annapolis, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrall Vascular Accident	Two days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] H. Parakhoodi MD	P15623	December 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
H. Parakhoodi, MD 900 Caton Ave. Baltimore, MD, 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 17 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Dolinskij, Michail

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42764

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Francis Hitchens Eberhardt	December 26, 2001	9:45 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Residence: 1518 Frenchtown Road	Perryville	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
717-07-5507	1☒M 2☐F	88 Yrs.			May 19, 1913	Delaware

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Perryville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1518 Frenchtown Road	21903	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Twelve Years		Electrician	Pennsylvania Railroad

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Leander Eberhardt	Nellie Naomi Hitchens

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Blanche Elmira Eberhardt (wife)	1518 Frenchtown Road, Perryville, Maryland 21903

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Mark's Cemetery	12/29/01	Perryville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas M. Patterson, Sr.	Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Interstitial Pulmonary Fibrosis — 12 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ prashant shukla MD	D0004805O	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Prashant Shukla, M.D. 319 South Union Avenue Havre de Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Eberhardt

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42765

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wanda Enoch
2. Date of Death: Month 12 Day 23 Year 2001
3. Time of Death: 4:45 am

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 245-94-8236
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-17-1957
9. Birthplace (State or Foreign Country): Burlington, NC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3727 Donnell Dr.
10f. Zip Code: 20747
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Certified Nurses Aid
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Hardy Bumper
18. Mother's Neme (First, Middle, Maiden Surname): Clara Satterfield

19a. Informant's Name/Relationship (Type, Print): Clara Satterfield/Mother
19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3727 Donnell Dr., Forestville , MD 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Snowhill Cemetery
Date: 12/29/01
20c. Location - City or Town, State: Mebane, North Carolina

21. Signature of Funeral Service Licensee: ▶ K. D. Marshall
22. Nama and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, Md 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

445A SR

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wanda Enoch 12/23/01

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. — Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure
Due to (or as a consequence of):
b. cardiac arrest
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. HIV - AIDS
Due to (or as a consequence of):
d. Seizure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.
Anemia, acute loss

23b. Did **tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy tindings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ M Piraino MD
29c. Licensa number: D0030246
29d. Date signed (Month, Dey, Year): 12/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOEZ PIRAINO AMED MD 7B POST OFFICE RD MD 20602

(5)

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

DEC 2 7 2001 OSTI

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42766

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arthur Harry Ernst

2. Data of Death Month / Day / Yaer: December 22, 2001

3. Tima of Death: 8:25PM

4a Facility Nema *(If not institution, give street and number)*: 4209 Dunnel Lane

4b. City, Town, or Location of Deeth: Kensington

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 577-56-9781

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 59 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Day, Year)*: Sept 7, 1942

9. Birthplaca *(State or Foraign Country)*: Connecticut

Usual Rasidence of Decedent

10e. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 10907 Lombardy Road

10f. Zip Code: 20901

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Nevar Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒Yas 2☐No If Yas, Giva Yaer or Dates: 1968-1970

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐Yes 2☒No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16e. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Lawyer

16b. Kind of Businass/Industry: IRS

17. Father's Nema *(First, Middla, Last)*: Harry A. Ernst

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Melina Aluise

19e. Informant's Name/Relationship *(Type, Print)*: Melina A. Ernst/ Mother

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 4209 Dunnel Lane, Kensington, MD 20895

20a. Mathod of Disposition: 1☒Burial 2☐Cremetion 3☐Ramoval from State 4☐Donation 5☐Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crametory or other placa)*: Gate of Heaven Cemetery | Data: Dec 27 2001

20c. Location - City or Town, Stata: Silver Spring, MD

21. Signature of Funeral Service Licensee: William F Byrd

22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daeth. Do not antar tha mode of dying, such as cardiec or respiretory errest, shock, or haart failura. List only ona causa on aach line. | Approximata Intarval Between Onset and Deeth

Immediata Causa (Final diseasa or condition resulting in death):
a. Probable myocardial infarction — DMF
Due to (or es e consequenca of):
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequanca of):
d.

Sequentiellly list conditions, if any, leeding to immadieta causa. Entar Underlying Cause (Disaasa or Injury thet initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Ware autopsy findings available prior to complation of cause of death? 1☐Yas 2☒No

25. Was case referred to medical examiner? 1☒Yas 2☐No

26. Placa of Death *(Check only ona)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA | Other: 4☐Nursing Homa 5☐Residence 6☒Othar *(Specify)* Mothers Residence

27. Mennar of Deeth: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigetion 6☐Could not be datarmined

28e. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledga, daeth occurred at tha time, dete end place, and dua to the cause(s) end menner es stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the tima, data and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: Ira N Brecher MD ME

29c. Licansa number: D00428

29d. Data signed *(Month, Day, Year)*: Dec 22 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira N. Brecher, MD DME 2101 Medical Park Drive, Silver Spring, MD 20902

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 28 2001

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42767

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BESSIE EPSTEIN
2. Date of Death (Month, Day, Year): DECEMBER 24, 2001
3. Time of Death: 7:05 AM
4a. Facility Name (If not institution, give street and number): MONTGOMERY VILLAGE CARE AND REHAB. CENTER
4b. City, Town, or Location of Death: MONTGOMERY VILLAGE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 092-10-9215
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 10, 1910
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: MONTGOMERY VILLAGE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19301 WATKINS MILL ROAD
10f. Zip Code: 20886
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): DEWEY HACK
18. Mother's Name (First, Middle, Maiden Surname): DOROTHY (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): SUSAN UNGER-DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 DUKE CT ROCKVILLE, MD 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS
Date: 12/26/2001
20c. Location - City or Town, State: OLNEY, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. myocardial infarction — minutes
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 20148
29d. Date signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Steven Dolinsky MD 911 Russell Ave. Gaithersburg, Md.

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42768

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty June Ermer

2. Date of Death — Month: Dec. Day: 9, Year: 2001

3. Time of Death: 4:00 am

4a. Facility Name *(If not institution, give street and number)*: 668 Kensington Avenue

4b. City, Town, or Location of Death: Severna Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-20-6437

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 29 1926

9. Birthplace *(State or Foreign Country)*: MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 668 Kensington Avenue

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Charles J. Hoffman

18. Mother's Name *(First, Middle, Maiden Surname)*: Carolyn E. Hutchins

19a. Informant's Name/Relationship *(Type, Print)*: Richard Ermer/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 668 Kenginston Avenue, Severna Park, MD 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Woodlawn Cemetery

Date: Dec. 12 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Barranco & Sons

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock or heart leilure. List only one cause on each line.

Approximata Interval Between Onset end Death

Immediate Cause (Final disaesa or condition resulting in death): a. Metastatic colon cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated avents resulting in death) Last

b.

Due to (or as e consequence ol):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None Known

23b. Did tobacco use contributa to the causs of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28l. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard Saiontz

29c. License number: Md. # D15552

29d. Date signed *(Month, Day, Year)*: 12/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard Saiontz, M.D. 23 Crossroads Dr. Ste #340 Owings Mills, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 10 2001

32. Registrar's Signature: Geneva P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amendment to #18, 12/28/01, ham, Cecil Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42769

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES E. FRANKS, Sr.

2. Date of Death: Month 12 Day 19 Year 2001

3. Time of Death: 4:05 PM

4a. Facility Name (If not institution, give street and number): 125 Channel Buoy RD

4b. City, Town, or Location of Death: Ocean City

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 196-28-3376

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 63 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07 21 1938

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 125 Channel Buoy RD

10f. Zip Code: 21842

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): owner/operator

16b. Kind of Business/Industry: food service

17. Father's Name (First, Middle, Last): Lester Franks

18. Mother's Name (First, Middle, Maiden Surname): Margaret McCallister ~~Geraldine M. Metague~~

19a. Informant's Name/Relationship (Type, Print): Geraldine M. Franks wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 125 Channel Buoy Rd. Ocean City MD 21842

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Philadelphia Crematories, Inc.

Date: 12-22-01

20c. Location - City or Town, State: Philadelphia Pennsylvania

21. Signature of Funeral Service Licensee: ▶ Timothy J. Meyer KI-0000553

22. Name and Address of Facility: Beeson Memorial Services 2053 Pulaski Hyw Newark, DE 19702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC LUNG CANCER — 5 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ R.L. Clinton, MD

29c. License number: D0056776

29d. Date signed (Month, Day, Year): 12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Clinton, MD 145 E. Carroll St. Suite A1 Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

from Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42770

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ray Edward Firebaugh
2. Data of Death (Month, Day, Year): December 22, 2001
3. Time of Death: 12:10 pm
4a. Facility Name (If not institution, give street and number): 3418 Lottsford Vista Road
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-12-4618
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1919
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3418 Lottsford Vista Road
10f. Zip Code: 20721
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Private Business

17. Father's Name (First, Middle, Last): David William Firebaugh
18. Mother's Name (First, Middle, Maiden Surname): Ella Smith Young

19a. Informant's Name/Relationship (Type, Print): JoAn S. Firebaugh - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3418 Lottsford Vista Road, Mitchellville, MD 20721

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 12/26/01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of the colon with metastasis — 6 year

Due to (or as a consequence of):
b. to the lungs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: 025079
29d. Date signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Don H. Yablonowitz, MD 7404 Executive Place #502, Lanham, MD 20706

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State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

DEC 5 2001

(5)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42771

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
ETHEL FOSTER		12	22	2001	5:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES COUNTY HOSPITAL	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-32-5140	1☐ M 2☑ F	88 Yrs.					07-10-1913	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	PRINCE GEORGES	GLENARDEN	1☑ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7907 FISKE AVENUE	20706	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Give Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12th		DOMESTIC WORKER	PRIVATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FRANK TUCKER	ELIZABETH BRIDGEFORTH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GLORIA CANADY - DAUGHTER	7907 FISKE AVENUE; GLENARDEN, MD 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MARYLAND NATIONAL Cemetery	12/28/01	LAUREL, MD

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
▶	MD1251	BIANCHI FUNERAL SERV 814 UPSHUR ST NW WASH DC

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only *one* cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Ventricular fibrillation	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): b.	Acute myocardial infarction	hours
Due to (or as a consequence of): c.	Diffuse Coronary atherosclerosis	years
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, Hypertension with hypertensive cardiovascular disease, Hyperlipidemia; Anemia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ RR Rustagi MD	D24720	12-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6132 Landover Road, RAVINDER K. RUSTAGI MD Cheverly MD 20785

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Gordon B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42772

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID B. FEDER

2. Date of Death (Month, Day, Year): December 25, 2001

3. Time of Death: 9:38P.M.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montogmery

Funeral Director

5. Social Security Number: 330-26-9990

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 7, 1927

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9900 Bedfordshire Court

10f. Zip Code: 20854

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1953-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Consulting Engineer Architectual Firm

17. Father's Name (First, Middle, Last): Aaron Harry Feder

18. Mother's Name (First, Middle, Maiden Surname): Ida Bender

19a. Interment's Name/Relationship (Type, Print): Frances Feder - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9900 Bedfordshire Court Potomac, Maryland 20854

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens

Date: 12/27/2001

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Myocardial Infarction — 1 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Daniel Rosenblum MD

29c. License number: D04766

29d. Date signed (Month, Day, Year): December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daniel Rosenblum, M.D. 10400 Connecticut Avenue, #606 Kensington, Maryland 20895

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Department of Health and Mental Hygiene, Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Feder, David B 12/25/01 2138

18

DEC S A SOD

RKD

01-7266-029

PENNY

FALL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42773

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Penny J. Fall

2. Deta of Death Month / Dey / Yaer: DECEMBER 22, 2001

3. Time of Death: 3:50P.M.

4a Facility Neme *(If not institution, give street end number)*: RT.291

4b. City, Town, or Location of Death: CHESTERTOWN

4c. County of Death: KENT

Funeral Director

5. Social Security Number: 017-32-6313

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Yeer)*: Jan. 10, 1941

9. Birthplace *(Steta or Foraign Country)*: Massachusetts

Usuel Residence of Decedent

10a. Stata: Md

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒Yas 2☐No

10e. Street and Number: 103 Southgate

10f. Zip Code: 21620

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+): 4 + 2

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: College Professor/Phys. ED.

16b. Kind of Business/Industry: Washington College

17. Father's Name *(First, Middle, Last)*: Kingsley R. Fall

18. Mother's Neme *(First, Middle, Meiden Surnema)*: Jessie Shanks

19e. Informant's Neme/Reletionship *(Type, Print)*: Holly Malarney (Sister)

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 50 Boatswains Way #205 Chelsea, MA 02150

20e. Method of Disposition: 1☐Burial 2☒Crametion 3☐Remaval from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Ches. Cremation Center

Dete: 12/26/01

20c. Location - City or Town, Stete: Stevensville, Md.

21. Signature of Funeral Service Licensee: Kirk D. Fellenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter tha mode of dying, such es cardiac or respiretory arrest, shock, or heert feilura. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): e. MULTIPLE INJURIES

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an eutopsy performed? 1☒Yas 2☐No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☒Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes cese referred to medical exeminer? 1☒Yes 2☐No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* SCENE

27. Menner of Death: 1☐Naturel 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*: 12 22 01

28b. Time of Injury: 14:20 PM

28c. Injury et Work? 1☐Yes 2☒No

28d. Describe how injury occurred: DRIVER OF CAR, IMPACT WITH A VEHICLE

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: ROADWAY

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*: RT291 CHESTERTOWN KENT CO MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the causa(s) and manner es stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or Investigetion, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) and manner steted.

29b. Signature and titla of certifier: Marjorie McKell MD

29c. Licansa number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: DECEMBER 23, 2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): MARJORIE A. MCKELL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Yeer)*: DEC 26 2001

32. Registrer's Signeture: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42774

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Linda		Fisher	11	29	01	21:39 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shock Trauma Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-92-4963	1☐M 2☒F	42 Yrs.					July 7, 1959	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Queen Anne	Crumpton	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
32 Matthew Drive	21628	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1979-81	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	0	Landscaper	Agriculture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ronald Richard Fisher	Beverly Ann Gustafson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Beverly Gustafson (Mother)	9944 Fairlee Road Chestertown, Maryland 21620

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ches. Cremation Cntr.	12/01/01	Stevensville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road Chestertown, Maryland 21620

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	one month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown		
24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No	

25. Was case referred to medical examiner? 1☒Yes 2☐No	26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)			
27. Manner of Death 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day, Year) 10/24/01	28b. Time of Injury 00:44 M	28c. Injury at Work? 1☐Yes 2☒No	28d. Describe how injury occurred Motor Vehicle Crash
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Bridge			28f. Location (Street and Number or Rural Route Number, City or Town, State) Bay Bridge Queen Anne County, MD

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	P13691	11/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maurizio Miglietta 22 South Greene St., Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 05 2001	[signature] D. Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42775

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James Arthur Fraser	Dec 26 2001	240 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12442 Black Mesa Trail	Lusby	Calvert

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☐F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
032 24 3346	X	65			Feb 23 1936	Massachusetts

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Calvert	Lusby	1☐Yes X☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12442 Black Mesa Trail	20657	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	X☐Yes 2☐No If Yes, Give Year or Dates 55-58	1☐Yes X☐No Specify:	Specify White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		planning & installation Engineer	RCA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roy Donald Fraser	Grace Caswell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Virginia B Fraser - wife	12442 Black Mesa Trail Lusby MD 20657

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Maryland Veterans Cemetery	Jan 3 2002	Cheltenham Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ BRausch	Rausch Funeral Home PA 4405 Brromes Is. rd. Port Republic MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. primary hepatocellular carcinoma	7 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

insulin dependent type 2 diabetes

porphyria cutanea tarda.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Jarath Fears	MD29522	12/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J Fears 110 Hospital Rd. Fr. Frederick MD 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 02 2002	▶ Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

14+ 19 at h

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42776

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Martha Helen Faulds	Dec. 26, 2001	3:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Asbury Health Care Center	Solomons	Calvert County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-16-7500	1☐M 2☒F	97 Yrs.			March 28, 1904	Germany

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Calvert Co.	Solomons	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11750 Asbury Circle	20688	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Florist	Florist Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gottlieb Schatz	Martha Leyh

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret Hayes (Daughter)	501 Aldersgate Ct., Solomons, MD 20688

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Prospect Hill Cem.	Dec., 29, 2001	Washington, D.C.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Lee Funeral Home Calvert, P.A. 20736 8125 Southern Maryland Blvd., Owings, MD

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the causa of death?	24a. Was en autopsy performed?	24b. Were eulopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Yeer)
▶ John H. Weigel	D26358	DEC. 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John H. Weigel, M.D. 10845 Town Center Blvd., Dunkirk, MD 20754

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	▶ Geneva G Sparks

5

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42777

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margarita Freivalds

2. Date of Death Month / Day / Year: December 22, 2001

3. Time of Death: 1:50 AM

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-42-3930

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 18, 1914

9. Birthplace *(State or Foraign Country)*: Latvia

Usual Residence of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 501 Gilmoure Drive

10f. Zip Code: 20901

10g. Citizen of Whet Country?: United States of America

11. Merital Status: 1☐ Nevar Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highast grada completed)*: Elementery/Secondery (0-12): 12 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Nama *(First, Middle, Last)*: Emils Dzenis

18. Mother's Nama *(First, Middla, Maiden Surnama)*: Elizabeth Straume

19a. Informent's Neme/Raletionship *(Type, Print)*: John Freivalds / Son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 5160 Colonial Drive; Golden Valley, MN 55416

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramovel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetary, cramatory or othar place)*: Loudon Park Crematory

Date: 12/26/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature] GF

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such es cardiac or raspiretory arrast, shock or heart feilura. List only ona causa on aach lina.

Approximeta Intarval Batween Onset and Death

Immedieta Causa (Final diseasa or condition resulting in death)

a. Bilateral Pneumonia — 1 Week

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or injury that initieted avents resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Due to (or es a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying ceuse given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availeble prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Wes cesa refarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Deeth *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datermined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daeth occurred at tha tima, date and place, and due to tha causa(s) and mennar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, data end piece, and dua to tha cause(s) and mannar stated.

29b. Signeture and title of certifier: Peter S. Birk, M.D.

29c. License number: D00150 60

29d. Date signed *(Month, Day, Year)*: December 22, 2001

30. Nama and addrass of person who complated causa of daeth (Item 23a) (Type, Print): Peter S. Birk, M.D. 10829 Georgia Ave., #T-2, Silver Spring, MD 20902

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 27 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42778

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dorothy Dempsey Fry	December 22, 2001	5:45 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery Hospice- Casey House	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☒F	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-28-7678		80 Yrs.			Nov 13, 1921	DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Kensington	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9405 Byeforde Road	20895	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Antique Dealer	Antiques

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Mills Dempsey	Agnes Catherine Haase

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Patricia Carlin/ Daughter	4903 Bangor Drive, Kensington, MD 20895

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	Dec 22, 2001	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Francis J. Collins Funeral Home,Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Renal Failure	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Hypertension	years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Triadriplegia

Coronary Artery Disease

Anemia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D 15046	December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen J. Newman, MD 19261 Montgomery Village Avenue, Montgomery Village, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	▶ [signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42779

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mark Wayne Grayson
2. Data of Death Month Day Year: December 24, 2001
3. Time of Death: 16:35
4a. Facility Name *(If not institution, give street and number)*: 4 Rock Creek Drive
4b. City, Town, or Location of Death: North East
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 412-23-2356
6. Sex: [X] M [ ] F
7. Age *(In yrs. last birthday)*: 40 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: November 23, 1961
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4 Rock Creek Drive
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Framer
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Walter Clarence Grayson
18. Mother's Name *(First, Middle, Maiden Surname)*: Darlene Nesbitt

19a. Informant's Name/Relationship *(Type, Print)*: Gail Patricia Grayson/ Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4 Rock Creek Road, North East, Maryland 21901

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: R.A. Ferris Company — Date: December 27, 2001
20c. Location - City or Town, State: West Chester, Pennsylvania

21. Signature of Funeral Service Licensee: Robert T. Crouch
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Suicide - Gun shot wound — Immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: December 24, 2001
28b. Time of Injury: 16:35 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Self inflicted gun shot wound to head
28a. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*: At home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 4 Rock Creek Drive, North East, MD

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Farkas, MD
29c. License number: D15314
29d. Date signed *(Month, Day, Year)*: December 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H Farkas, MD Union Hospital, Elkton, MD 21921

State Registrar

31. Date Filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42780

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALAN GINN

2. Date of Death Month Dey Year: DECEMBER 24 2001

3. Time of Death: 0745

4e. Facility Name *(If not institution, give street and number)*: Laurelwood Nursing Home Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 215-12-7993

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 3-4-1914

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: Md.

10b. County: Cecil

10c. City, Town or Location: Cecilton

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: RFD # 1 BOX 430

10f. Zip Code: 21913

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Auto Assembly worker

16b. Kind of Business/Industry: Auto Manufacturing

17. Father's Name *(First, Middle, Last)*: Fred A. Ginn

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Atwell

19e. Informant's Name/Relationship *(Type, Print)*: Katherine Ginn-Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: RFD #1 Box 430,Cecilton,Md. 21913

20e. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Capitol Cremation

Date: 12-26-01

20c. Location - City or Town, State: Dover, DE.

21. Signature of Funeral Service Licensee: Richard A. Hutchison

22. Name and Address of Facility: DANIELS & HUTCHISON 212 N. Broad st.,Middletown,DE.19709

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ayton MD

29c. License number: D54073

29d. Date signed *(Month, Day, Year)*: 26 DEC 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arlen Stone, MD 817 CHURCHMANS CTR NEWCASTLE DE 19720

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001

32. Registrar's Signature: Janice B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #5 &19b PER FH G804 2/01/02 JH

Certificate of Death

Reg. No. 2001 42781

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH W. GRIFFIN
2. Date of Death (Month, Day, Year): DEC. 24, 2001
3. Time of Death: 8:40 AM
4a. Facility Name (If not institution, give street and number): NATIONAL LUTHERAN HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY CO.

Funeral Director

5. Social Security Number: 001-42-~~3598~~ 3595
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 8, 1909
9. Birthplace (State or Foreign Country): MASSACHUSETTS

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9701- VEIRS DRIVE
10f. Zip Code: 20850
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: AT HOME

17. Father's Name (First, Middle, Last): HARRY WOODIN
18. Mother's Name (First, Middle, Maiden Surname): MARIE DRISCOLL

19a. Informant's Name/Relationship (Type, Print): DEBORAH SCARBROUGH-DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 ~~ELYTON~~ LEYTON CT., ROCKVILLE, MD. 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. CALVARY CEMETERY
Data: 1/4/02
20c. Location - City or Town, State: MANCHESTER, N.H.

21. Signature of Funeral Service Licensee: ▶ W.M. Hysong
22. Name and Address of Facility: HYSONG CO., INC. 6510- 16th ST., NW, WASH., DC

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 3 weeks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia
gastrointestinal bleeding
Alzheimers Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D50612
29d. Data signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SAMUEL MALLER - 9701 VEIRS DR ROCKVILLE. MD

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42782

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Margaret N. Garrett	DECEMBER 26, 2001	4:10 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Community Hospital	Lanham	Prince George's

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578 18 6562	1 ☐ M XX F	87 Yrs.			Jan 20, 1914	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Brandywine	1 ☐ Yes XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12503 Bredon Court	20613	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed XX 4 ☑ Divorced	1 ☐ Yes 2 XX No If Yes, Give Year or Detes:	1 ☐ Yes 2 XX Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Homemaker	At Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Arthur Compton	Sarah Eva Thatcher

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helen E. Kittredge (DAUGHTER)	12503 Bredon Court, Brandywine, Maryland 20613

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Cedar Hill Cemetery	12/31/2001	Suitland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Charles L. Bélanger	Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. VIRAL SYNDROME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

LEFT VENTRICULAR DysFunction
Chronic Obstructive Pulmonary Disease with Emphysema
Hypothyroid disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yas 2 ☑ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yas 2 ☑ No	1 ☐ Yas 2 ☐ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Homa 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Wilhelmina M Cruz	D20633	12/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILHELMINA M CRUZ M.D. 7700 Old Branch Ave Door Clinton Md 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GARRETT, MARGARET

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42783

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
HAZEL	GOODWIN		DECEMBER 18, 2001	4:50A M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
DOCTORS HOSPITAL	Lanham		Prince Georges	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-68-2101	1☐M 2☒F	53 Yrs.			Jan. 27, 1948	Wash. D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Lanham	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5707 Lyngate Court	20706	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Team Leader Supv.	Verizon Telephone

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frederick General	Jamesie Wilson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Harold F. Goodwin Son	5707 Lyngate Court, Lanham, Md. 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parklawn Cem.	12/27	Rockville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Francis B. Hunt	Hunt Funeral Home 908 Kennedy St. N.W. WAsh. D.C. 20011

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrythmia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Lung.
Pneumonia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Naturet 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D57028	12/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
621 Didgely Rd Suite 401 Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	Barbara B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death:
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Goodwin, Hazel

12

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42784

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
JEANETTE GATLING	December 21, 2001	5:00 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8813 Oak Lane	Ft. Washington	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247-54-5391	1☐ M 2☒ F	67 Yrs.			Jan. 27, 1934	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Ft. Washington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8813 Oak Lane	20744	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Supervisor	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James McFarland	Louvenia Scott

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ray L. Gatling, Sr. - Husband	8813 Oak Lane, Ft. Washington, MD 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Harmony Memorial Park	12/27/2001	Landover, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John T. Stewart III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardio Pulmonary Arrest	1 Day
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Hepatic Metastasis From The Breast	3 Months
	Due to (or as a consequence of):	
	c. Carcinoma Of The Right Breast	8/99
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Massive Ascites

Post Operative Right Colectomy

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W W Funderburk	1984	December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William W. Funderburk, M.D. 106 Irving St., N.W. #222, Wash., DC 20010

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

DEC 7 e 5001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 42785

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ALPHONSO DUDLEY GILLIS, JR.	DECEMBER 17, 2001	9:00P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1615 SHAMROCK AVE.	CAPITAL HEIGHTS	PRINCE GEROGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-62-8997	1 XX M 2 ☐ F	56 Yrs.			SEPT. 24, 1945	WASHINGTON, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYALND	PRINCE GEORGES	CAPITAL HEIGHTS	1 XX Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1615 SHAMROCK AVENUE	20743	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XX No If Yes, Give Year or Dates:	1 ☐ Yes 2 XX No Specify:	Specify: BALCK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH		CARPENTER	PRIVATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ALPHONSO GILLIS, SR.	MARY GORHAM

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LILLIE HAGGINS-GILLIS / WIFE	1615 SHAMROCK AVE. CAPITAL HEIGHTS, MARYALND

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, State
1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	METROPOLITAN CREMATORY	12-27-2001	ALEXANDRIA, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
J. P. Marshall	MARSHALL'S FUNERAL HOME OF MARYLAND, INC 4308 SUITLAND ROAD SUITLAND, MARYLAND 20746

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Daath
Immediate Cause (Final disease or condition resulting in death)	a. HEPATIC FAILURE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CARCINOMA OF THE LIVER	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XX Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XX No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 XX No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D23743	DECEMBER 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN D. WELTZ, MD 7525 GREENWAY CT. GREENBELT, MARYLAND 20770

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	[signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

DEC 2 6 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42786

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Vera Alice Grenke	December 10, 2001	6:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Magnolia Hall Nursing Center	Chestertown	Kent

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-60-9423	1☐M 2☒F	83 Yrs.			Jan. 20, 1918	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Kent	Rock Hall	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7080 Tolchester Road	21661	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9	0	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Charles Packer, Sr.	Minnie Florence Hess

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Charles Grenke (Son)	47 Appleseed Lane Gaithersburg, Md. 20878

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Wesley Chapel Cem.	12/12/2001	Chestertown, Md

21. Signature of Funeral Service Licensee: Kirk of Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A 6179 Rock Hall Road Rock Hall, Md. 21661

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — 6 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Jack G. Myers MD	D-0013824	12-11-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. John C. Seymour 122 Speer Road Chestertown, Md. 21620

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 14 2001	Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 42787

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Augustine Gentile
2. Date of Death (Month, Dey, Yeer): December 21, 2001
3. Time of Death: 11:25 PM
4a. Facility Neme (If not institution, give street and number): 14106 Valley Field Drive #4
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Socisl Security Number: 182-09-9077
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 2, 1917
9. Birthplece (State or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. Stete: Delaware
10b. County: Sussex
10c. City, Town or Location: Ocean View
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: Route 1, Box 90
10f. Zip Code: 19970
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: WWII
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Statistician
16b. Kind of Business/Industry: Federal Government

17. Father's Neme (First, Middle, Last): Agostino Gentile
18. Mother's Name (First, Middle, Maiden Surname): Rosina Varanti

19e. Informent's Neme/Reletionship (Type, Print): Mary O'Connell Gentile / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 1, Box 90, OceanView, DE 19970

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — Date: Dec 27 2001
20c. Location - City or Town, Stete: Silver Spring, MD

21. Signeture of Funeral Service Licensee: ▶ Eric S. Scerbo
22. Neme and Address of Feclity: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. list only one ceuse on eech line. — Approximete Intervel Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth):
a. Renal Failure

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in death) Last
b. Invasive Transitional Carcinoma of Prostate

Due to (or es e consequence of):
c.

Due to (or es a consequence of):
d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings sveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughters Residence

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: ▶ Michael J. Stanton MD
29c. License number: D 22953
29d. Date signed (Month, Day, Year): December 26, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. Stanton, MD 10215 Fernwood Road #630, Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrer's Signeture: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

6F

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15+1 yr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42788

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Helen H. Gillespie	December 26, 2001	1:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care- Bethesda	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
115-14-0328	1☐ M 2☒ F	78 Yrs.			July 12, 1923	New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Virginia		Alexandria	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1202 S. Washington Street, #324	22314	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Real Estate Agent	Real Estate

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Alfred Loveland Haffner	Helen Myers

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alexander H. Gillespie / Son	4318 Underwood Street, Hyattsville, MD 20782

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Gate of Heaven Cemetery	Dec 29, 2001	Mt. Pleasant, NY

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Andrew J. Cole	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Felel death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown		
	24a. Was an autopsy performed? 1☐ Yes 2☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No	28. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)			
27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M.D.	D 54347	December 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kailash C. Chopra, MD 121 Congressional Lane #409 Rockville, MD 20852

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Geneva D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42789

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Robert Gillette

2. Date of Death (Month, Day, Yaer): December 26, 2001

3. Time of Death: 3:40 PM

4a. Facility Nama (If not institution, giva street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 479-26-4760

6. Sex: 1☒ M 2☐ F

7. Aga (In yrs. last birthdey): 73 Yrs.

If Under 1 Yaer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 9, 1928

9. Birthpleca (State or Foraign Country): Indiana

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5615 Northfield Road

10f. Zip Code: 20817

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Raca - American Indien, Black, Whita, etc.: Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): – ; College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Biochemical Pharmacologist

16b. Kind of Business/Industry: National Institutes of Health

17. Father's Neme (First, Middle, Last): Clinton Edgar Gillette

18. Mother's Name (First, Middla, Maiden Surnema): Celia Rogers

19a. Informent's Name/Reletionship (Type, Print): Rema Joan Reed Gillette/ Wife

19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5615 Northfield Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piace of Disposition (Neme of cemetery, crematory or other piece): Parklawn Memorial Park

Date: January 2, 2002

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: [signature] M00689

22. Name end Address of Fecility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode ot dying, such es cardiac or raspiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete intarval Batween Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)

a. Pneumonia

Due to (or es a consequenca of):

Sequentieily list conditions, if any, leeding to immediete causa. Enter Underlying Ceuse (Diseesa or Injury thet initieted events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

Dua to (or es a consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other signiflcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contributa to ths causs of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding invastigetion 6☐ Could not be determined

28a. Deta of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: [signature]

29c. Licensa number: 026259

29d. Data signed (Month, Dey, Year): 12/27/01

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): Ava A. Kaufman, M.D. 4930 Del Ray Avenue, Bethesda, Maryland 20814

State Registrar

31. Dete filed (Month, Dey, Year): DEC 28 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

60

Gillette, James 12-26-01 15:40

RKD

01-7277-033

PELAEZ
GONZALEZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 041702:ITEMS#23a,27,28a-f per ME G806 — *Certificate of Death*

Reg. No. 2001 42790

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francisco Gonzalez

2. Date of Death (Month, Day, Year): DECEMBER 23, 2001

3. Time of Death: 10:31A.M.

4a. Facility Name (If not institution, give street and number): 3517 TOLEDO TERRACE

4b. City, Town, or Location of Death: HYATTSVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-93-6435

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 21 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec.2,1980

9. Birthplace (State or Foreign Country): Mexico

Usual Residence of Decedent

10a. State: Md

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2016 Oglethorpe St. #3

10f. Zip Code: 20782

10g. Citizen of What Country? Mexico

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: Mexican

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Laborer

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Francisco Gonzalez

18. Mother's Name (First, Middle, Maiden Surname): Lorenza Pelaez

19a. Informant's Name/Relationship (Type, Print): Jaime Gonzalez/Uncle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2104 Ravenswood St.Hyattsville,Md 20782

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Guadelupe Santa Ana

Date: 1/02/02

20c. Location - City or Town, State: Santa Ana, Mexico

21. Signature of Funeral Service Licensee: Philip D. Rinaldi

22. Name and Address of Facility: Philip D.Rinaldi Funeral Service 9241 Columbia Blvd,Silver Spring,Md20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GF

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARBON MONOXIDE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): Found: 12-23-01

28b. Time of Injury: Found: 10:10a M

28c. Injury at Work? 1 [X] Yes 2 [ ] No

28d. Describe how injury occurred: Subject inhaled automobile exhaust fumes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found in parked auto

28f. Location (Street and Number or Rural Route Number, City or Town, State): 3517 Toledo Terrance, Hyattsville, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pestaner, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42791

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Ernest Green

2. Dete of Deeth — Month: Dec; Dey: 8; Year: 2001

3. Time of Death: 11:00PM

4e Facility Name *(If not institution, give street end number)*: 1036 East College Parkway

4b. City, Town, or Location of Deeth: Annapolis

4c. County of Deeth: Anne Arundel

Funeral Director

5. Sociel Security Number: 215-16-5787

6. Sex: XM 2☐F

7. Age *(In yrs. last birthdey)*: 91 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: July 1 1910

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: XYes 2☐No

10e. Street and Number: 1036 East College Parkway

10f. Zip Code: 21401

10g. Citizen ot Whet Country?: USA

11. Meritet Stetus: 1☐Never Merried XMerried 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes XNo If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐Yes XNo *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 6th; College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Horse Trainer

16b. Kind of Business/Industry: Self Employed

17. Father's Neme *(First, Middle, Last)*: John Green

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Bessie Colbert

19a. Informent's Neme/Reletionship *(Type, Print)*: Carrie Green (Wife)

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1036 East College Parkway Annapolis,Md 21401

20e. Method ot Disposition: XBurieI 2☐Cremetion 3☐Removel trom Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory, or other place)*: Asbury Broadneck Church Cemetery

Dete: 12/13/01

20c. Location - City or Town, Stete: St. Margarets,Md.

21. Signeture of Funerel Service Licensee: Harry D. Reese M00482

22. Neme and Address of Facility: Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart tailure. List *only one* ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in deeth)

a. pancreatic cancer — 2 months

Due to (or es e consequence ot):

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

prostat cancer

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☐No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes case referred to medicel examiner? 1☐Yes 2☐No

26. Piece ot Deeth *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

26a. Dete of Injury *(Month, Dey Yeer)*

28b. Time ot Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, term, street, tactory, office building, etc. *(Specify)*

28t. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medicel Exeminer:** On the basis ot exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier: CMH/S

29c. License number: D0052783

29d. Date signed *(Month, Dey, Yeer)*: 12/11/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia Wood Huffaker 207 Ridgely Ave. Annapolis MD 21401

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 12 2001

32. Registrer's Signeture: Lenore B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42792

GLORIA M. HECK

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Gloria Marie Heck		DECEMBER 29 2001	6:30pm M
4a. Facility Name (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death	
Nolen @ Riverside	Belcamp	HARFORD	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
214-22-7468	1☐M 2☒F	76 Yrs.			Nov. 15, 1925	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Perryville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
423 Sumpter Drive	21903	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Eleven Years		Homemaker	Personal Residence

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middla, Meidan Sumama)
Ernest D. Smith, Sr.	Bessie Jane Pierce

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Charles Donald Heck, Jr. (son)	531 Aiken Avenue, P.O. Box 108, Perryville, Maryland 21903

20a. Method of Disposition	20b. Place of Disposition (Nama of cematary, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Harford Memorial Gardens	01/03/02	Aberdeen, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas N. Patterson, Sr.	Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Renal Failure

Due to (or as a consequence of):

c. Arterio sclerotic cardiovascular disease

Due to (or as e consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnency	23d. Dsie of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only ona)	
1☐Yes 2☐No	Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J.T. Lee MD	D20661	1/30/01

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

J.T. Lee MD 665 Revolution St. Havre de Grace MD 21078

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signature
DEC 31 2001	Sandra D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42793

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH HOTRA
2. Date of Death (Month, Day, Year): December 24 2001
3. Time of Death: 1810
4a. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 215-30-5504
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 16, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Chesapeake City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 288 Randalia Road
10f. Zip Code: 21915
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Retail Hardware

17. Father's Name (First, Middle, Last): Alexander Hotra
18. Mother's Name (First, Middle, Maiden Surname): Tekla Podvirna

19a. Informant's Name/Relationship (Type, Print): Valerie H. Walls/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 288 Randalia Road, Chesapeake City, MD 21915

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Rose of Lima Cemetery
Date: 12-28-01
20c. Location - City or Town, State: Chesapeake City, MD

21. Signature of Funeral Service Licensee: Richard L. Goodie
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 318 George Street, Chesapeake City, MD 21915

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — 6hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

HISTORY OF LUNG CANCER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mayekumpla M.D.
29c. License number: D005 1197
29d. Date signed (Month, Day, Year): DEC. 25th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAYA GUPTA 110 W 9th STREET #320, WILMINGTON, DE 19801

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Lynn D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12+1VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42794

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jerry Everett Hall, Sr.	December 21, 2001	0736 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Hospital	Elkton	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-46-3460	1 X M 2 ☐ F	55 Yrs.			May 6, 1946	Tennessee

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Elkton	1 ☐ Yes XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
379 Bouchelle Road	21921	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
11		Concrete Worker	Concrete

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Quincey Hall	Merle J. Campbell

19a. Interment's Neme/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Kathy Johnson/ Sister	379 Bouchelle Road, Elkton, Maryland 21921

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1 ☐ Buriel 2 XX Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	R.A. Ferris & Company, Inc.	December 27 2001	West Chester, Pennsylvania

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert T. Crouch	Crouch Funeral Home 127 South Main Street, North East, Maryland 21901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Lung

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of deeth 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 X Unknown	
24a. Was en autopsy performed? 1 ☐ Yes 2 X No	24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death 1 X Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end manner es steted.
2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Jun Carl Hall MD	D048023	12/21/2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
223 W. Main Street, Elkton, Maryland 21921

To be completed by the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Dey, Year) DEC 27 2001

32. Registrar's Signature Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #3. Per Phys. & #'s 10f. 15. 19b. Per FH PGC 1-3-02 cr

Certificate of Death

Reg. No. 2001 42795

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene Joseph Herbert

2. Date of Death Month Day Year: December 19, 2001

3. Time of Death: 9:12 p.m. ~~9:00 a.m.~~

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 166-42-7728

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 07, 1949

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6113 39th Place

10f. Zip Code: ~~20781~~ 20782

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): ~~4~~

College (1-4or 5+): 5±

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Engineer

16b. Kind of Business/Industry: Federal Government

17. Father's Neme (First, Middle, Last): John M. Herbert

18. Mother's Neme (First, Middle, Maiden Surneme): Eleanor M. Sekula

19a. Informent's Neme/Relationship (Type, Print): Kathleen Herbert - Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6113 39th Place., Hyattsville, MD ~~20781~~ 20782

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Holy Redeemer Cemetery

Dete: 12-27-01

20c. Location - City or Town, Stete: Philadelphia, Pennsylvania

21. Signature of Funeral Service Licensee: Edward May

22. Name and Address of Facility: Gasch's Funeral Home P.A. 4739 Baltimore Avenue., Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that cesed the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth): a. Aspiratn Pneumth. — 1 hour

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Penging Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Donald Siel

29c. License number: D 45660

29d. Date signed (Month, Day, Year): 12-21-01

30. Nama and address of person who completed cause of death (item 23a) (Type, Print): 14300, GALLANT FOX LN 124, BOWIE MD 20715

State Registrar

31. Date filed (Month, Dey, Year): DEC 28 2001

32. Registrer's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 2 9 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42796

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William A. Hilleary, JR.
2. Date of Death (Month, Day, Year): December 26, 2001
3. Time of Death: 9:16 A.M.
4a. Facility Name (If not institution, give street and number): 102 E. Hawthorne DR.
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 578-44-7975
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/18/1933
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: La Plata
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 102 East Hawthorne Drive
10f. Zip Code: 20646
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952-1954
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate
16b. Kind of Business/Industry: Sales

17. Father's Name (First, Middle, Last): William A. Hilleary Sr.
18. Mother's Name (First, Middle, Maiden Surname): Ruth Campbell

19a. Informant's Name/Relationship (Type, Print): Tracy H. Brosnan / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2113 Blue Knob Terrace Silver Spring, MD 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.
Date: 01/03/2002
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Ischemic heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner es stated. 2 [X] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Yahia M. Taqouri
29c. Licensa number: D0050883
29d. Date signed (Month, Day, Year): Dec. 26. 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YAHIA M. TAQOURI M.D 11655 WINESAP PL LA PLATA MD 20646

State Registrar

31. Data filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Geraldine B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(10)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42797

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Clarence Hatley
2. Date of Death (Month, Day, Year): Dec. 26, 2001
3. Time of Death: 2:22 P.M.
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 414-14-7633
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 14, 1922
9. Birthplace (State or Foreign Country): Nashville, TN

Usual Residence of Decedent

10a. State: MD.
10b. County: Prince Georges
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9602 Shuttle Court North
10f. Zip Code: 20772
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Treasury Department
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): James B. Hatley
18. Mother's Name (First, Middle, Maiden Surname): Agnes M. Connell

19a. Informant's Name/Relationship (Type, Print): Bruce Hatley (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 378 Lankford Road, Harwood, MD. 20776

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Maryland Veterans Cem.
Date: 1/4/02
20c. Location - City or Town, State: Cheltenham, MD.

21. Signature of Funeral Service Licensee: Lee R. Pate
22. Name and Address of Facility: 6633 Old Alexandria Ferry Rd., Clinton, MD. 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Large intra cerebral bleed : basal ganglia — < 48 hours

Due to (or as a consequence of):
b. Hypertension — 10 years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: history of Alcohol usage

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alain G. Champagne MD
29c. License number: D42049
29d. Date signed (Month, Day, Year): december 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alain. G. CHAMPAGNE MD. Upper Marlboro MD 20772.

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

arrived on 12-26-2001 @ 2:22 pm.

Hatley John

CF

(15) 11/9

ORIGINAL

DEC 5 8 500

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item#5 per infmnt G805 032102 ss
Amend #21. Per FH PGC 12-27-01 cr

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42798

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maurine C. Higgins

2. Date of Death Month Dey Year: DECEMBER 14 2001

3. Time of Death: 09:54 P.M.

4a. Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: ~~307-10-7265~~ ~~301-32-1247~~

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Jan.23,1908

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Virginia

10b. County: Fairfax

10c. City, Town or Location: Annandale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 4003 Justine Drive

10f. Zip Code: 22003

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Th; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Frank Clark

18. Mother's Name *(First, Middle, Maiden Surname)*: Diana Wiley

19a. Informant's Name/Relationship *(Type, Print)*: R. Clark Higgins (Son)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 13822 Foggy Hills Ct.,Clifton,Va.20124

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetery, crematory or other piece)*: Everly Wheatley Crematory

Dete: 12/24/01

20c. Location - City or Town, Stete: Alexandria,Virginia

21. Signature of Funeral Service Licensee: ~~J.Mc Taggart~~ Mear

22. Name and Address of Facility: Everly Community Funeral Care 6161 Leesburg Pk.,Falls Church,Virginia,22044

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in death)

a. UROSEPSIS — 02 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE — 02 DAYS

Due to (or as a consequence of):

c. MYOCARDIAL INFARCTION — 02 DAYS

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC MYELOGENOUS LEUKEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were sutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peerach Phermsangngam MAJ

29c. License number: CA 060847

29d. Date signed *(Month, Day, Year)*: DECEMBER 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PEERACH P. PHERMSANGNGAM, MAJ, USAF, MC 89MDG/1050 W. PERIMETER RD. ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001

32. Registrar's Signature: Jennifer D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(15)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42799

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert Manuel Holtz

2. Date of Death Month / Day / Year: Dec 22nd 2001

3. Time of Death: 6 45 Am

4a. Facility Name *(If not institution, give street and number)*: Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-26-3035

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 15, 1921

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No

10e. Street and Number: 6111 Montrose Road

10f. Zip Code: 20852

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: General Contractor

16b. Kind of Business/Industry: Self employed

17. Father's Name *(First, Middle, Last)*: Isadore Holtz

18. Mother's Name *(First, Middle, Maiden Surname)*: Leah Jacobs

19a. Informant's Name/Relationship *(Type, Print)*: Terri Holtz, daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3210 Wisconsin Ave., N.W., #301 Washington, D.C. 20016

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Memorial Garden | Date: 12/23/2001

20c. Location - City or Town, State: Falls Church, Virginia

21. Signature of Funeral Service Licensee: Donald K Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach lina. | Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. acute cardio-pulmonary arrest

Due to (or as a consequence of):
b. acute respiratory failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. pulmonary fibrosis (severe)

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

Coronary artery disease

Obesity Constipation

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☑ Nursing Home 5 ☐ Residance 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Consuelo Alvarez

29c. License number: D: 44907

29d. Date signed *(Month, Day, Year)*: Dec 22nd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Consuelo Alvarez, MD 6105 Montrose Road Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001

32. Registrar's Signature: Sandra B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Holtz, Herbert

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42800

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Emma Harris	12 22 2001	4:55 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
152-66-3024	1☐M 2☒F	36 Yrs.			09-14-1965	New Jersey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Laurel	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13402 Arden Way Apt.#8	20708	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4yrs	Manager Gift Specialist	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George H. Poole, Sr.	Shirley Tillotson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michael Harris/ Husband	13402 Arden Way #8, Laurel,MD. 20708

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rock Creek Cemetery	12/28/01	Washington, DC

21. Signature of Funeral Service Licensee: K. D. Marshall

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover, Rd., Landover, MD. 20785

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Pulmonary Emboli	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D24819	12/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRUCE ZINSMEISTER MD 8830 CAMERON ST SILVER SPRING MD 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 2 7 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42801

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clifford P. Houston
2. Date of Death (Month, Day, Year): December 18, 2001
3. Time of Death: 9:35 A.M
4a. Facility Name (If not institution, give street and number): Bowie Health Center
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 241 54 3434
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 13, 1937
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: [X] 1 Yes 2 [ ] No
10e. Street and Number: 3116 Trinity Drive
10f. Zip Code: 20715
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Furniture Store

17. Father's Name (First, Middle, Last): Perry Houston
18. Mother's Name (First, Middle, Maiden Surname): Katie Shook

19a. Informant's Name/Relationship (Type, Print): Maureen A. Houston Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3116 Trinity Drive Bowie Maryland 20715

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Dec. 21, 2001
20c. Location - City or Town, State: Silver Spring Maryland

21. Signature of Funeral Service Licensee: Michael L. Sisk
22. Name and Address of Facility: Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach lina.

Immediata Cause (Final disease or condition resulting in death): a. CARDIOGENIC SHOCK — Approximate Interval Between Onset and Daath: FEW HRS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b. CORONARY ARTERY DISEASE — Due to (or as a consequence of):
c. — Due to (or as a consequance of):
d. — Due to (or as a consequance of):

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal deeth 3 [ ] Ectopic pregnency 4 [ ] Pregnent at time of deeth 5 [ ] Other (specify) ____ 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco usa contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [X] Other (Specify) BOWIE HEALTH CENTER

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Angela L. Gudi MD
29c. License number: D31345
29d. Date signed (Month, Day, Year): 12-20-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4000 Blythewood Road Bowie Md 20716

State Registrar

31. Date filed (Month, Dey, Year): DEC 26 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 2 8 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42802

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VINA B. HILLS
2. Data of Death — Month: Dec. Day: 24 Year: 2001
3. Time of Death: 8:57PM
4a. Facility Name (If not institution, give street and number): Potomac Valley Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 264-40-3524
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept. 16, 1919
9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 5711 Dimes Road
10f. Zip Code: 20855
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Day Care Nursing Ass't
16b. Kind of Business/Industry: Child Care

17. Father's Name (First, Middle, Last): Johnny Brown
18. Mother's Name (First, Middle, Maiden Surname): Callie Branton

19a. Informant's Name/Relationship (Type, Print): Gwendolyn Dickie (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5711 Dimes Road, Rockville, MD 20855

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Park Cemetery — Date: 12/31/2001
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: Snowden Funeral Home P.A. 246 N Washington St Rockville, MD 20850

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

D

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CVA

Due to (or as a consequence of):

c. COPD

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frauke Westphal M.D.
29c. License number: D0019785
29d. Date signed (Month, Day, Year): Dec. 26th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frauke Westphal, M.D. 809 Veirs Mill Road, Rockville, MD 20851

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42803

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ESTELLA N. HOSPITAL	DEC. 22, 2001	6:45 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MONTGOMERY GENERAL HOSPITAL	OLNEY	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-12-2667	1☐M 2☒F	84 Yrs.			JAN. 21, 1917	WASH. D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	MONTGOMERY	ROCKVILLE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13006 FREELAND RD.	20850	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		HOUSEWIFE	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HENRY NICOL	FANNIE UNKNOWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JAMES D. HOSPITAL/SON	10800 LITTLEFORD LN., KENSINGTON, MD. 20895

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CHAMBERS CREMATORY	12-24-2001	RIVERDALE, MD.

21. Signature of Funeral Service Licensee: ▶ W.W. Chambers M00091

22. Name and Address of Facility: 5801 CLEVELAND AVE., RIVERDALE, MD. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 20737

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. UROSEPSIS	one week
	Due to (or as a consequence of): c. CHRONIC RENAL FAILURE	YEARS.
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ G. Thaler, M.D.	D43430	December, 23rd, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3411 OLANDWOOD CT, #105, OLNEY, MD 20832, GAURANG THALER, MD.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	▶ Suzanne G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42804

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Hoan Huynh
2. Deta of Deeth — Month: December; Dey: 17; Yeer: 2001
3. Time of Death: 6:15 PM
4a. Facility Name *(If not institution, give street and number)*: Heartland Health Care Center
4b. City, Town, or Location of Death: Adelphi
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 586-18-6633
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 100 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Houra / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Oct 13, 1901
9. Birthplece *(Stete or Foreign Country)*: China

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Streel and Number: 1727 Loft Way
10f. Zip Code: 20904
10g. Citizen of Whet Country?: USA

11. Maritef Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detes:
13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yes, apecify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Asian

15. Decedent'a Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 3; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father'a Neme *(First, Middle, Last)*: Trung Huynh
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Ngoc Tat

19e. Informent's Neme/Reletionship *(Type, Print)*: Muoi Tu / Son
19b. Meiling Address *(Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 1727 Loft Way, Silver Spring, MD 20904

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Diaposition *(Neme of cemetery, crematory or other place)*: George Washington Cemetery
Dete: Dec 28, 2001
20c. Location - City or Town, Stete: Adelphi, MD

21. Signeture of Funeral Service Licensee: John C. [illegible]
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth)
a. Arteriosclerotic Cardiovascular Disease — years

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last
b.
Due to (or es e consequence of):
c.
Dua to (or as a consequance of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wea en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy tindings aveileble prior to completion of ceuse ot death? 1☐ Yas 2☒ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, streel, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Paul A. DeVore
29c. License number: D 01852
29d. Dete signed *(Month, Dey, Yeer)*: December 20, 2001

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print): Paul A. DeVore, MD 4203 Queensbury Road, Hyattsville, MD 20781

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 24 2001
32. Registrer's Signeture: Geneva G. Sachs

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42805

Thelma Heins

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Thelma	K.	Heins	December 21 2001	1600 hrs

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Augsburg Lutheran Home	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-18-6252	1☐ M 2☒ F	96 Yrs.			July 12, 1905	Baltimore

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6825 Campfield Road, #3H	21207	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
	8	Receptionist	State of Maryland

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles William Klarner	Louisa Sophia Serbe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James K. Heins (son)	11224 Midvale Road Kensington, MD 20895

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory, Inc	Dec 24, 2001	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Neme and Address of Feciility
Lancelot Rapp	Rapp Funeral And Cremation Service 933 Gist Avenue Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. END STAGE CONGESTIVE HEART FAILURE	1 MONTH
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. ISCHEMIC HEART DISEASE	
	Due to (or es e consequence of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the causa of death?	24a. Wes an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of ceuse of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ Deborah I Pierce	MD 45931	December 21, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)
Deborah I Pierce 7220 Park Heights Avenue Baltimore, MD 21208

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
DEC 24 2001	▶ Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42806

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Saleh Issa Haddad
2. Date of Death (Month, Day, Year): December 21, 2001
3. Time of Death: 6:21 A M
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-78-3425
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 7, 1919
9. Birthplace (State or Foreign Country): Salt, Jordan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10112 Greenock Road
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 7
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Funeral Director
16b. Kind of Business/Industry: Mortuary Science

17. Father's Name (First, Middle, Last): Issa Haddad
18. Mother's Name (First, Middle, Maiden Surname): Frajieh Haddad

19a. Informant's Name/Relationship (Type, Print): Muntaha Haddad Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8876 Town & Country Blvd., E. Ellicott City, MD 21043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Dec. 24, 2001
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebral Vascular Accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Lung Cancer
c. Due to (or as a consequence of): 8279515
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Kraden MD
29c. License number: D05937
29d. Date signed (Month, Day, Year): 12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT KRADEN MD 2181 MEDICAL PARK DR. SILVER SPRING MD 20902

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42807

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Mary Jane Hall	December 10, 2001	5:45 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
68 Riverside Drive	Severna Park	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
231-26-7211	1☐M 2☒F	73 Yrs.			Sept. 14, 1928	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Severna Park	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
68 Riverside Drive	21146	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James H. Tays	Myrtle Carter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John W. Hall, Jr./Husband	68 Riverside Drive Severna Park, MD 21146

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory	December 12, 2001	Baltimore, MD

21. Signature of Funeral Service Licensee: James E. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused tha daath. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one causa on each lina.

		Approximata Interval Batwaen Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Probable Pneumonia	3 days
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last	b. Due to (or as a consequence of): End stage Chronic Obstructive Pulmonary Disease	> 2 years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yas 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

Paraplegia secondary to spinal abscess, Lung nodule

23a. Did tobacco use contribute to tha cause of death? 1☐Yas 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of daath?
1☐Yas 2☑No	1☐Yas 2☐No

25. Was case referred to medical examiner?	26. Place of Daath (Check only one)	
1☐Yas 2☑No	Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☑Rasidanca 6☐Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day, Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined		M	1☐Yas 2☐No	

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)	28f. Location (Straat and Numbar or Rural Route Numbar, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To tha bast of my knowledga, daath occurred at the tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
John F. Boone, MD	D52728	December 11, 2001

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): John F. Boone, M.D. 479 Jumpers Hole Road #304 Severna Park, MD 21146

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
DEC 17 2001	Brenda B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42808

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Harris

2. Data of Death Month: Dec Day: 8 Year: 2001

3. Time of Death: 4:00PM

4a. Facility Name *(If not institution, give street and number)*: Spa Creek Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-24-8111

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Nov. 15 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1135 Eastport Terrace

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietarian

16b. Kind of Business/Industry: Crownsville Hospital

17. Father's Name *(First, Middle, Last)*: William James

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Reed

19a. Informant's Name/Relationship *(Type, Print)*: Keith Harris (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 617 Tripp Creek Ct. Annapolis, Md. 21401

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hill Crest Cemetery Data: 12/13/01

20c. Location - City or Town, State: Annapolis

21. Signature of Funeral Service Licensee: Harry D. Reese M00482

22. Name and Address of Facility: Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident — 1M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D32036

29d. Date signed *(Month, Day, Year)*: 12/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary R Sprute 2108 D. Darcy Drive Chester, MD 21619

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 12 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42809

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN T. HENSON

2. Date of Death Month Day Year: DEC. 5 2001

3. Time of Death: 3:05 pM

4a. Facility Name (If not institution, give street and number): KNOLLWOOD MANOR NURSING HOME

4b. City, Town, or Location of Death: MILLERSVILLE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-26-3881

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 15 1929

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 468 GLEN MAR ROAD

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RECORD CLERK

16b. Kind of Business/Industry: NSA

17. Father's Name (First, Middle, Last): WILLIAM HENSON

18. Mother's Name (First, Middle, Maiden Surname): GERTRUDE GRAY

19a. Informant's Name/Relationship (Type, Print): CAROLYN L. HENSON (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7932 SILVER LEAF CT. GLEN BURNIE, MD. 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERAN CEMETERY

Date: 12/12/01

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Larry D. Reese #100483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death)

a. Arthritis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death: 2 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 38958

29d. Date signed (Month, Day, Year): 12/10/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dupont Simply Cullum 1413 Annapolis Road #106 Odenton MD 21113

State Registrar

31. Date filed (Month, Day, Year): DEC 11 2001

32. Registrar's Signature: Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 42810

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LUCILLE F HUTTON
2. Date of Death (Month, Day, Year): DEC 19 2001
3. Time of Death: 04:12PM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 231-14-4604
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-23-1923
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7901 Laurel Lake Ct.
10f. Zip Code: 20707
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Authur Ashby
18. Mother's Name (First, Middle, Maiden Surname): Jenny Addison

19a. Informent's Name/Relationship (Type, Print): James Hutton/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7901 Laurel Lake Ct Laurel, MD 20707

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans
Date: 12-28-01
20c. Location - City or Town, State: Cheltenham

21. Signature of Funeral Service Licensee: ▶ L. D. Marshall
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat diseese or condition resulting in death)	a. SEPSIS	2 WEEKS
Due to (or as a consequenca of):	b. END STAGE RENAL DISEASE	MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequenca of): c. CORONARY ARTERY DISEASE	MONTHS
	Due to (or as a consequenca of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ANEMIA

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes ~~2☐ No~~
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes ~~2☐ No~~

26. Place of Death (Check only one): Hospital: ~~1☐~~ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other (Specify)

27. Manner of Death: ~~1☐~~ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ~~1☐~~ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ SJupM MD
29c. License number: D0053150
29d. Date signed (Month, Day, Year): DEC 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAKUNNALA GUPTA 201-109 BACK RIVER NECK RD 21221 BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): DEC 24 2001
32. Registrar's Signature: Jennifer D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 3 1 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 42811

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Wesley Hurtt
2. Date of Death (Month, Day, Year): December 18, 2001
3. Time of Death: 5:40a.m.
4a. Facility Name (If not institution, give street and number): Kent & Queen Anne's Hospital
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 220-28-4710
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 14, 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Sudlersville
10d. Inside City Limits: 1 [ ] Yes 2 [ ] No
10e. Street and Number: 106 Linden Street
10f. Zip Code: 21668
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Antique Dealer
16b. Kind of Business/Industry: Furniture

17. Father's Name (First, Middle, Last): George Alfred Hurtt
18. Mother's Name (First, Middle, Maiden Surname): Rose Elizabeth Luff

19a. Informant's Name/Relationship (Type, Print): Linda Jean Steigerwald
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Linden St., PO Box 25, Sudlersville, MD 21668

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sudlersville Cemetery
Date: 12/21/2001
20c. Location - City or Town, State: Sudlersville, MD

21. Signature of Funeral Service Licensee: Gary B. Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, MD 21651

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC LUNG CANCER — 7/yr
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert S. Crum
29c. License number: D36054
29d. Date signed (Month, Day, Year): 12/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 120 Speer Rd Chestertown MD 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 19 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #26. 12/11/01, CWC, Kent Co.

Certificate of Death

Reg. No. 2001 42812

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Novella Hines

2. Date of Death (Month, Day, Year): December 6, 2001

3. Time of Death: 7:10 a.m.

4a. Facility Name (If not institution, give street and number): 325 Race Street

4b. City, Town, or Location of Death: Millington

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 207-12-6761

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 16, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Queen Anne's

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7040 Church Hill Road

10f. Zip Code: 21620

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Health Care Provider

16b. Kind of Business/Industry: Health

17. Father's Name (First, Middle, Last): William Fletcher Yates

18. Mother's Name (First, Middle, Maiden Surname): Martha Thomas

19a. Informant's Name/Relationship (Type, Print): Martha Ellen Thompson Cook

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 62, Millington, Maryland 21651

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): John Wesley Cemetery

Date: 12/14/2001

20c. Location - City or Town, State: Millington, MD

21. Signature of Funeral Service Licensee: ▶ Gary B. Fellows

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress St., Millington, MD 21651

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — 21 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hemorrhagic esophagitis

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) Niece's House

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Susan K. Ross M.D.

29c. License number: D17036-Md.

29d. Date signed (Month, Day, Year): 12/6/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Susan K. Ross M.D. 516 Washington Ave. Chestertown Md 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 11 2001

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42813

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM R. HANCOCK, JR.

2. Date of Death Month Day Year: December 18 2001

3. Time of Daath: 1132 AM

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Deeth: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-18-5603

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Yaar): December 13, 1919

9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Westover

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8130 Old Westover-Marion Road

10f. Zip Code: 21871

10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Automobile

17. Father's Nama (First, Middle, Last): William R. Hancock

18. Mother's Name (First, Middle, Maiden Surname): Ruby C. Morgan

19a. Informant's Name/Reletionship (Type, Print): William D. Hancock (Grandson)

19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8130 Old Westover-Marion Rd.-Westover, MD 21871

20a. Method ot Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Sunnyridge Memorial Park

Dete: 12/21/01

20c. Location - City or Town, Stete: Crisfield, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.

22. Nama and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St.- Crisfield, MD 21817

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter tha mode ot dying, such as cardiec or raspiratory arrast, shock, or heart tailure. List only ona cause on eech line.

Approximata Interval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Renal Failure.

Due to (or es a consequance of):

c. Pancytopenia.

Due to (or as a consequence of):

d. atrial fibrillation.

IF FEMALE:

23b. Was decedent pregnent in tha past 12 months? 1 [ ] Yas 2 [ ] No 9 [ ] Unknown

23c. If yas, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima ot daath 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

anasarca.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings availabla prior to compiation of cause ot deeth? 1 [ ] Yes 2 [ ] No

25. Wes case refarred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datermined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Numbar or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best ot my knowledga, daath occurrad at the time, date and place, end due to the cause(s) end mennar as statad. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at tha time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier

29c. License number: D31546

29d. Dete signed (Month, Day, Year): 12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ignatius C. Dinardo M.D. / prac

State Registrar

31. Date filed (Month, Day, Year): DEC 2 7 2001

32. Registrar's Signature: Bonnie G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

213-18-5603

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

William Hancock

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42814

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Theresa Marie Ifkovits	DECEMBER 24 2001	6:34 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Community Hospital	Lanham	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
206-28-2491	1☐M 2☒F	64 Yrs.			May 12, 1937	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Prince Georges	Bowie	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2814 Botany Lane	20715	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	Horse Racing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Delano S. Proctor	Mary Groff

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lisa Chesnick daughter	12503 Brewster Lane, Bowie, Md. 20715

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Resurrection Cem.	12-29-01	Clinton, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrythmia — 1/2 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiomyopathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D 43668	12-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
14300, GALLANT FOX CIR 124, BOWIE MD 20715

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42815

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
PEARL	MARTHA	JONES	DEC.	20,	2001	8:16 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES GENERAL HOSPITAL	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
212-21-1858	1☐M 2☒F	69 Yrs.					OCT. 12,1932	GRENADA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	PRINCE GEORGES	RIVERDALE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6304 KENNEDY ST.	20737	GRENADA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FRANKLIN CALLISTE	LYRIS MORRIS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BASIL CALLISTE/SON	6304 KENNEDY ST., RIVERDALE, MD. 20737

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CHAMBERS CREMATORY	12-29-2001	RIVERDALE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
W.W. Chambers M00091	5801 CLEVELAND AVE.,RIVERDALE,MD. CHAMBERS FUNERAL HOME & CREMATORIUM,P.A. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ANOXIC ENCEPHALOPATHY	1 MO
Due to (or as a consequence of):	b. CARDIAC ARREST	1 MO
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ACUTE MYOCARDIAL INFARCTION	1 MO
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

PNEUMONIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes ☒No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
Linda D Green MD	D21428	12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA D GREEN MD, 3001 HOSPITAL DR, CHEVERLY, Md. 20785

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
DEC 27 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MEM

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42816

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DIANE L. JONES
2. Data of Death Month Day Year: DECEMBER 16, 2001
3. Tima of Death: 7:20am
4a Facility Nama (If not institution, giva street and number): CHESAPEAKE HOSPICE HOUSE
4b. City, Town, or Location of Deeth: LINTHICUM
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Sacurity Numbar: 218-62-9842
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 45 Yrs. If Under 1 Yaar: Months / Deys; If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 10-16-1956
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedant

10a. Stata: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 3002 CHERRY LAND RD. APT F
10f. Zip Coda: 21225
10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:
13. Was Decedant of Hispenic Origin? (Specify Yas or No- II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highast grada compiatad): Elamantery/Secondary (0-12): -12- ; College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): HOMEMAKER
16b. Kind of Businass/Industry: DOMESTIC

17. Fathar's Nama (First, Middle, Last): JOHN W. JONES
18. Mothar's Nama (First, Middle, Maidan Surnama): LUCILLE PARKER

19a. Informant's Name/Ralationship (Type, Print): MARQUERITE BROWN(SISTER)
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 15 A BENA DRIVE ANNAPOLIS, MARYLAND 21403

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): METRO CREMATORY
Data: 12-18-2001
20c. Location - City or Town, Stata: BALTIMORE, MARYLAND

21. Signatura of Funaral Service Licensaa: ▶ Larry G. Reese M00483
22. Nama and Addrass of Facility: WM. REESE & SONS MORTUARY 821 WEST ST. ANNAPOLIS, MARYLAND 21403

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)
a. end-stages AIDS — 15 months
Dua to (or as a consaquanca of):
b. HIV — 10 years

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated events resulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☑ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death (Check only ona)
Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5☐ Rasidanca 6☑ Othar (Specify) Hospice

27. Mannar of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)
28l. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifier: ▶ S. Thomp M.D. (medical resident)
29c. Licanse number: P15628
29d. Dete signed (Month, Day, Year): December 18, 2001

30. Nama and addrass of parson who compiated causa of daath (Item 23a) (Type, Print): S. Thompson St. Agnes Hosp 900 Caton Ave. Baltimore MD 21229

State Registrar

31. Data filed (Month, Day, Year): DEC 19 2001
32. Registrar's Signatura: P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42817

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE JENNINGS
2. Date of Death (Month, Day, Year): DEC. 6 2001
3. Time of Death: 4:30 a M
4a. Facility Name (If not institution, give street and number): 1184 SUMMERFIELD ROAD
4b. City, Town, or Location of Death: GAMBRILLS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213-22-0435
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 31 1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GAMBRILLS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1184 SUMMERFIELD ROAD
10f. Zip Code: 21054
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th
College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): LAUNDRY SERVICE
16b. Kind of Business/Industry: FT. GEORGE MEADE

17. Father's Name (First, Middle, Last): SUMMERFIELD BOSTON
18. Mother's Neme (First, Middle, Maiden Surname): ELIZA CARR

19a. Informant's Name/Relationship (Type, Print): HARRY JENNINGS (SON)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 884 BRIGHTON PLACE GLEN BURNIE, MD. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. TABOR UM CHURCH CEMETERY
Dete: 12/10/01
20c. Location - City or Town, Stete: CHESTERFIELD, MD.

21. Signature of Funeral Service Licensee: ▶ Larry G. Reese M00483
22. Name and Address of Facility: WILLIAM REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Stroke
Due to (or as e consequence of):
b. Alzeimer's disease
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet intieted events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnency 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown
24e. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. Licanse number: D25654
29d. Date signed (Month, Dey, Yeer): 12/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YEONG OH 1417 CROWN N GB. MD 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 11 2001
32. Registrar's Signature: ▶ Denise B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42818

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eleanor Martha Jarva

2. Date of Death (Month, Day, Year): December 21, 2001

3. Time of Death: 11:32 pm

4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 198-10-8510

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 19, 1919

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 58G Ridge Road

10f. Zip Code: 20770

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretarial

16b. Kind of Business/Industry: Private Business

17. Fether's Neme (First, Middle, Last): Stephen J. Coady

18. Mother's Neme (First, Middle, Maiden Sumeme): Elizabeth O'Brien

19a. Informent's Neme/Reletionship (Type, Print): Kenneth V. Jarva - Son

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 8T Plateau Place, Greenbelt, MD 20770

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Metropolitan Crematory

Dete: 12/27/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funerel Service Licensee: Arlen Smith

22. Name end Address of Fecility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediete Cause (Finel disease or condition resulting in deeth)

a. Ruptured Abdominal Aortic Aneurysm — 5 Hours

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other signiflcant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cauee of death?** 1☐ Yee 2☐ No 3☐ **Probably** 4☒ **Unknown**

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one) Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: John J. Sandler

29c. License number: D0001802

29d. Date signed (Month, Dey, Year): December 27, 2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Steven C. Sandler, M.D., 7500 Hanover Parkway, Ste. #205, Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Dey, Year): DEC 28 2001

32. Registrer's Signeture: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Amend #5 Per Fam. PGC 1-7-02 cr
Amend #4a Per Phys. PGC 12-28-01 cr

Certificate of Death

Reg. No. 2001 42819

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise Joiner

2. Date of Death (Month, Day, Year): December 19, 2001

3. Time of Death: 1130

4a. Facility Name (If not institution, give street and number): 6801 ~~Bock~~ Bock Road #432

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-22-~~2532~~ 2352

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-25-1921

9. Birthplace (State or Foreign Country): Gastonia, NC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6801 Bock Rd. Apt. #432

10f. Zip Code: 20744

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Walter Clemmer

18. Mother's Name (First, Middle, Maiden Surname): Janie Wallace

19a. Informant's Name/Relationship (Type, Print): Shirley Williams / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5327 85th Ave. Apt. 101 New Carrollton, MD 20784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Riverdale Crematory

Date: 12-22-01

20c. Location - City or Town, State: Riverdale, MD

21. Signature of Funeral Service Licensee: K. D. Marshall

22. Name and Address of Facility: JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester, DO

29c. License number: H0055927

29d. Date signed (Month, Day, Year): December 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester 3001 Hospital Drive, Cheverly, Maryland 20784

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Gordon B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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(3)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12/27/01 Amend # 23a. State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Prt. 1.& II Per Phys.PGC cr *Certificate of Death* Reg. No. 2001 42820

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Susie	M.	Jones	DECEMBER 24 2001	12:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Community Hospital	Lanham	Prince Georges

Funeral Director

5. Social Security Number	8. Sex 1 M 2 F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
224-34-4896	XX	93			June 17 1908	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	New Carrollton	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5416 85th. Ave. #102	20784	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	College (1-4or 5+)		
9	0	Domestic Worker	Self-Employed

17. Father's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surnema)
Nathaniel Harris	Ann Unk.

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Ruth N. Hicks (Daughter)	5416 85th. Ave. #102 New Carrollton, MD 20784

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cramatory or othar piece)	Date	20c. Location - City or Town, Stata
1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Othar (Specify)	Harmony Memo. Park	12/28/01	Landover, MD

21. Signature of Funeral Service Licensee	22. Nama and Addrass of Facility
Richard Bauer	Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the daath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death)
a. Cardiac Arrest Respiratory failure — Min. hours

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Cardiac Arrythmias — Min.
c. Due to (or as a consequence of): Metabolic Acidosis — Hours
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yas, outcoma of pragnancy 1 Live birth 2 Fatal daath 3 Ectopic pregnancy 4 Pregnant at tima of daath 5 Othar (specify) 9 Unknown	23d. Data of dalivary Month Day Year

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease
Metabolic Acidosis, Cardiac Arrythmias
Hypertensive Cardiovascular Disease
Cirrhosis of liver, Renal insuficency

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 Unknown	1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 Yas 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Othar (Specify)

27. Manner of Daath	28a. Date of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicida 5 Pending investigation 6 Could not be datarmined		M	1 Yes 2 No	
	28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurrad at tha time, data and place, and due to the cause(s) and mannar as statad.
2 **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
Neelam Ashai M.D	D48213.	12-26-2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Neelam Ashai 4410 74th Ave landoverhills MD 20784.

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
DEC 27 2001	Gordon G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Susie Jones

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42821

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LUCILLE L. JOHNSON
2. Date of Death (Month, Day, Year): DEC. 23 2001
3. Time of Death: 901A
4a. Facility Name (If not institution, give street and number): HARBORSIDE LARKIN CHASE HEALTHCARE
4b. City, Town, or Location of Death: BOWIE
4c. County of Death: PRINCE GEORGE

Funeral Director

5. Social Security Number: 414 18 6773
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-30-06
9. Birthplace (State or Foreign Country): MISSISSIPPI

Usual Residence of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: WASH DC
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 118 - 11TH ST. N.E.
10f. Zip Code: 20002
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 yrs. / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSE WIFE
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): LUTHER BROWN
18. Mother's Name (First, Middle, Maiden Surname): CALLIE JONES

19a. Informant's Name/Relationship (Type, Print): ROGER I. MORRIS / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2627 32ND ST. SE WASH DC 20020

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY MEM. PK. Date: 12/29/01
20c. Location - City or Town, State: LANDOVER, MD

21. Signature of Funeral Service Licensee: Juan Smith
22. Name and Address of Facility: JOHN T. RAINES CO. 3030-[illegible] ST. NE WASH DC 20017

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death) a.	Sepsis	1 week
Due to (or as a consequence of): b.	Ischmic limb	weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Peripheral vascular occlusive disease	yrs
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Acute Renal Failure

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature]
29c. License number: D32261
29d. Date signed (Month, Day, Year): 12-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard J. Feldman MD 9500 Annapolis rd, Lanham 20706

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42822

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA HARRIED JEFFERSON
2. Date of Death: Month December Day 18 Year 2001
3. Time of Death: 1:23 P.M.
4a. Facility Name (If not institution, give street and number): Prince Georges Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-30-1997
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-09-20
9. Birthplace (State or Foreign Country): Annapolis, MD

Usual Residance of Decedant

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 1006 Larchmont Avenue
10f. Zip Coda: 20743
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highast grada completed): Elamentary/Secondary (0-12): Collega (1-4or 5+): 2
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Time and Leave Clerk
16b. Kind of Business/Industry: Dept. of H.U.D. Federal Gov't

17. Fathar's Nama (First, Middle, Last): William Harried
18. Mothar's Nama (First, Middle, Maidan Surnama): Mary Taylor

19a. Informant's Name/Relationship (Type, Print): Julia Veronica Randle / Daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1006 Larchmont Avenue, Capitol Heights, MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Harmony Memorial Park
Data: 12/24/01
20c. Location - City or Town, Stata: Landover, MD

21. Signature of Funaral Service Licensee: Derek E. Bloom
22. Nama and Address of Facility: Strickland Funeral Services, P.A. 6500 Allentown Rd, Camp Springs, MD 20748

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List *only one* causa on aach lina.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death)
a. Cardiac and Respiratory Failure
Dua to (or as a consequance of):
b. Chronic Cerebro-vascular disease s/p CVA
Dua to (or as a consequance of):
c. Organic brain disease with
Dua to (or as a consequance of):
d. dementia

Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disaase or Injury that initiated avents rasulting in death) Last

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.
1. Hypertension
2. Hyperlipsdevise

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Placa of Daath (Check only ona)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA
Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: Piotr L Grojec, M.D.
29c. Licanse number: D0046671
29d. Data signed (Month, Day, Year): 12-20-2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): PIOTR L. GROJEC, M.D. 6400 Marlboro Pike, District Heights, MD 20747

State Registrar

31. Data filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signatura:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42823

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ESSIE MAE JEFFERSON
2. Date of Death (Month, Day, Year): December 19, 2001
3. Time of Death: 9:15 P.M.
4a. Facility Name *(If not institution, give street and number)*: Forrest Glen Nursing Home
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-22-0233
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 15, 1912
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5014 Roseld Court
10f. Zip Code: 20745
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: William Oscar James
18. Mother's Name *(First, Middle, Maiden Surname)*: Canary Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Carolyn M. Crockett - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5014 Roseld Ct., Oxon Hill, MD 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery
Date: 12/26/2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. STROKE — unknown

Due to (or as a consequence of):
b. Dia Betes — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 50454
29d. Date signed *(Month, Day, Year)*: December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arastoo Yazdani, M.D. 9801 Georgia Ave., #3-35, Silver Spring, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 26 2001
32. Registrar's Signature: Barbara P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

DEC 2 8 2001 1005 U.S. DOC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42824

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
SHARON	JACKSON.		12- 19- 2001	7.20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctor's Hospital	Lanham	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-74-2276	1☐M 2☒F	43 Yrs.			06- 13- 58	Newark, NJ

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Springdale	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9219 Gary Lane	20774	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2yrs.	Administrative Assistant	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Herbert Jackson, Sr.	Macie McCullough

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Herbert Jackson, Sr./ Father	10800 Brookes Reserve Rd. UpperMarlboro, MD 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Harmony Memorial Park	12/27/01	Landover, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. D. Marshall	JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrythmia — Few mnts.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Sepsis — 24-48 HRS.
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☒Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Porcasi

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ P. Ausla MD Attending	D42580	12.19.01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5632 Annapolis R #13.
P.S. AUSLA MD Attending BLADENSBURG, MD-20710.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42825

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norma Lee Jester
2. Date of Death (Month, Day, Year): December 24, 2001
3. Time of Death: 3:15a.m.

4a. Facility Name *(If not institution, give street and number)*: Kent & Queen Anne's Hospital, Inc.
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 215-26-2604
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: September 26, 1929
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Millington
10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 1706 Dudley Corner Road
10f. Zip Code: 21651
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Robert Levin Foxwell
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes May Davis

19a. Informant's Name/Relationship *(Type, Print)*: Harry Paul Jester, Sr./Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1706 Dudley Corner Road, Millington, MD 21651

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Crumpton Cemetery
Date: 12/29/2001
20c. Location - City or Town, State: Crumpton, Maryland

21. Signature of Funeral Service Licensee: Gary B. Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, MD 21651

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOPULMONARY ARREST
Due to (or as a consequence of):
b. Respiratory Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Severe CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
POOR NUTRITION, HISTORY OF SEVERE DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: J.C. Arkabal Jr. M.D.
29c. License number: D23889
29d. Data signed *(Month, Day, Year)*: 12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. ARKABAL JR. M.D. 223 High Street Chestertown, Md 21620

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #8, 1/3/02, GF, Mont.Co. AMEND #5, 12/26/2001, BMW, Montg.Co. *Certificate of Death* Reg. No. 2001 42826

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Pauline	Ruth	Kreh	December 23, 2001	0410 AM M

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Casey House 6001 Muncaster Mill Road	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~800-14-1101~~ 578-40-0867	1☐ M 2☒ F	87 Yrs.			Nov. ~~11~~ 01, 1914	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
800 Silver Spring	20910	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Raca - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumeme)
George Hall	Effie Grimm

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Louis V. Kreh Jr. (Son)	P.O. Box 925 Madison VA 22727

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory	12-26-01	Beltsville, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Rapp Funeral And Cremation Service 933 Gist Avenue Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Metastatic Lung Cancer	Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were eutopsy lindings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case relerred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28l. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ [signature] MD	D 15046	December 23, 2001

30. Name and address ol person who completed cause ol death (Item 23a) (Type, Print): Steven Newman, MD 6001 Muncaster Mill Road Rockville, MD 20855

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
DEC 26 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-l show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 (3)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42827

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis Kabran
2. Date of Death: Month December Day 23 Year 2001
3. Time of Death: 1655 PM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 170-09-9813
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 08, 1912
9. Birthplace (State or Foreign Country): Pennsylvania

Usuet Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 15101 Interlachen Dr. #914
10f. Zip Code: 20906
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1942 to 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUSINESS
16b. Kind of Business/Industry: OWNER

17. Father's Name (First, Middle, Last): ISADORE KABRAN
18. Mother's Name (First, Middle, Maiden Surname): ETHEL MAISEL

19a. Informent's Name/Relationship (Type, Print): EDYCE KABRAN-WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15101 INTERLACHEN DR #914 SILVER SPRING, MD 20906

20a. Method of Disposition: 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS — Date: 12/27/01
20c. Location - City or Town, State: OLNEY, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel diseese or condition resulting in deeth): CHRONIC MYELOMONOYTIC LEUKIMIA — Approximate Interval Between Onset and Death: MONTHS

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

a. ____ Due to (or as a consequence of):
b. ____ Due to (or as e consequence of):
c. ____ Due to (or as a consequence ot):
d. ____

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of death 5 ☐ Other (specify) ____ 9 ☐ Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 X No

28. Place of Death (Check only one): Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D35635
29d. Date signed (Month, Day, Year): DEC 24, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH KAPLAN 18111 PRINCE PHILIPP DR. OLNEY, MD 20832

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Benera G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42828

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ludmila Kalugin	December 20, 2001	7:05 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1909 Blackbriar St.	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-53-0629	1☐M 2☒F	66 Yrs.			09-22-1935	Russia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1909 Blackbriar St.	20903	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4 Yrs	Researcher	Healthcare

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Victor Ivanov	Maria Koshkina

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Oleg Kalugin/Husband	1909 Blackbriar St. Silver Spring, MD 20903

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ft. Lincoln Crematory	12/22/2001	Brentwood, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. Ewell	Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary failure	Acute
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Liver failure	Chronic
	Due to (or as a consequence of): c. Pancreatic Cancer	Chronic
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Wallmark M.D.	53177	Dec 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Wallmark, M.D. 10605 Concord St. Kensington, MD Suite 300

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Jeanne G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42829

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JESSIE	WEEKS	KEISER	12	21	2001	1:18 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SUBURBAN HOSPITAL	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
001-20-4872	1☐ M 2☒ F	74 Yrs.			AUG. 6, 1927	NEW HAMPSHIRE

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	BETHESDA	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7200 ARMAT DRIVE	20817	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	EXECUTIVE VICE PRESIDENT	PUBLISHING COMPANY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES RODERICK WEEKS	JOSEPHINE CURRIER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MATTHEW R. KEISER - SON	5635 OLDCHESTER RD., BETHESDA, MD. 20814

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ROCK CREEK CEMETERY	12/27/01	WASHINGTON, D.C.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nancy A. Pecanthe	JOSEPH GAWLER'S SONS, INC. 5130 WISC. AV. NW., WASHINGTON, DC. 20016

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Asystole — 5min.

Due to (or as a consequence of):

b. Sepsis. — 2 days.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D19609	12-21-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMAN R. TULI. M.D. 10810 DARNESTOWN ROAD #202, GAITHERSBURG, MD. 20878

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KEISER, JESSIE W. 12-21-01 01:18

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AACO HEALTH

AMEND#28a, 28b 12/17/01 per Phy. cmh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42830

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES H. KELLER, JR
2. Date of Death: Month Dec. Day 5, Year 2001
3. Time of Death: 11:45 pm
4a. Facility Name (If not institution, give street and number): 870 Mago Vista Road
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-46-1333
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 14, 1946
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 870 Mago Vista Road
10f. Zip Code: 21012
10g. Citizen of What Country? USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Programmer
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): James H. Keller, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Rachel Delamater
19a. Informant's Name/Relationship (Type, Print): Cathy Keller/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 870 Mago Vista Road, Arnold, MD 21012
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Dec. 6, 2001
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home, 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Metastatic Melanoma	6mos
Due to (or as a consequence of): b.	Extensive Bone metastases	6mos
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Intractable Pain	6mos
Due to (or as a consequence of): d.	Anemia	6mos

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): ~~12/05/01~~
28b. Time of Injury: ~~11:45 AM~~
28c. Injury at Work? 1 [ ] Yes 2 [✓] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D
29c. License number: D54413
29d. Date signed (Month, Day, Year): 12/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Young J. Lee, M.D 3001 S. Hanover St. Blto MD 21225

State Registrar

31. Date filed (Month, Day, Year): DEC 17 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42831

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert J. Kolscher

2. Date of Death Month / Day / Year: Dec. 14, 2001

3. Time of Death: 4:35 pm

4a. Facility Name *(If not institution, give street and number)*: 605 Pinetree Drive

4b. City, Town, or Location of Death: Severna Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-07-0095

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 22, 1921

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 605 Pinetree Drive

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Food Broker

16b. Kind of Business/Industry: Food Service

17. Father's Name *(First, Middle, Last)*: John L. Kolscher

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Allers

19a. Informant's Name/Relationship *(Type, Print)*: Ann Kolscher/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 605 Pinetree Drive, Severna Park, MD 21146

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Druid Ridge Cemetery — Date: Dec. 17 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas E. Allen

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failura. List only one causa on eech line. — Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)
a. PANCREATITIS / RECURRENT — 1 YEAR
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: CAD, Type 2 DM

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. O'Keefe

29c. License number: D35259

29d. Date signed *(Month, Day, Year)*: 12-17-01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Kevin O'Keefe, M.D., Benfield Rd. & Veterans Hwy, Millersville, MD 21108

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 17 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42832

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Edward William Klussmann	December 7 2001	6:15 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Heritage Harbour Health & Rehab. Ctr.	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
067-10-2756	1 [X] M 2 [ ] F	95 Yrs.			June 23, 1906	New Jersey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
517 Ridge Road	21401	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	+4	Partner/Member	New York Stock Exchange

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown	Minnie Vonglan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mildred Smith Klussmann (wife)	517 Ridge Rd. Annapolis, Maryland 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Baltimore Crematory	12/09/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Beverly Cm. Barton	John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. upper respivatory infection	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
S. Selonick MD	019898	12/8/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stuart E. Selonick, M.D. 900 Bestgate Rd. Annapolis, Md. 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 10 2001	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42833

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONNA LYNNE KAEHN
2. Date of Death (Month, Day, Year): DECEMBER 25, 2001
3. Time of Death: 3:05 P.M.
4a. Facility Name (If not institution, give street and number): 85 PARK LANE
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 218-46-1096
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 11, 1948
9. Birthplace (State or Foreign Country): DELAWARE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CECIL
10c. City, Town or Location: ELKTON
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 85 PARK LANE
10f. Zip Code: 21921
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GRAPHIC DESIGN
16b. Kind of Business/Industry: ADVERTISING JOURNALISM

17. Father's Name (First, Middle, Last): GEORGE KAEHN
18. Mother's Name (First, Middle, Maiden Surname): MARY JANE DAVIS

19a. Informent's Name/Relationship (Type, Print): GUINNEVERE HUGHES
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4541 SCHENLEY ROAD, BALTIMORE, MD 21210

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): ST. STEPHENS CEMETERY
Date: 12/29/01
20c. Location - City or Town, State: EARLEVILLE, MARYLAND

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: GEE FUNERAL HOME 259 E. MAIN ST. ELKTON, MD 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ovarian Cancer — Approximate Interval: 8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Tobacco Abuse

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No
25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Christine E.K. Horah DO
29c. License number: MD H0054380
29d. Date signed (Month, Day, Year): 12/29/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christine E.K. Horah D.O 412 Suburban Plaza, Newark, DE 1971

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001
32. Registrar's Signature: D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42834

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucy Missouri Keets
2. Date of Death Month Day Year: December 23, 2001
3. Time of Death: 2220 M
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-20-1679
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 4,1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Lothian
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 940 Marlboro Road
10f. Zip Code: 20711
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-Employed
16b. Kind of Business/Industry: Hotel

17. Father's Name (First, Middle, Last): George Richard Washington
18. Mother's Name (First, Middle, Maiden Surname): Phyllis Missouri

19a. Informant's Name/Relationship (Type, Print): Sherry Copeland (Niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 940 Marlboro Road Lothian Maryland 20711

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery
Date: Dec. 28, 2001
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: W. B Grasier
22. Name and Address of Facility: Lee Funeral Home, Inc. 20735
6633 Old Alexandria Ferry Road, Clinton, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic Shock

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Klebsiella UTI & bacteremia — 4 d
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cardiomyopathy

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D55458
29d. Date signed (Month, Day, Year): 12/24/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NANCY HEISEL, MD AAMC

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Brenda B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-7051-033
B.K.S
PRINCE KOROMA

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #5,Per FH PGC 12-27-01 cr

Certificate of Death

Reg. No. 2001 42835

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: PRINCE ANSU TIRO KOROMA
2. Date of Deeth Month: DEC. Dey: 14, Yeer: 2001
3. Time of Death: 5:35 AM
4e Facility Name *(If not institution, give street and number)*: 9007 ANNAPOLIS ROAD
4b. City, Town, or Location of Deeth: LANHAM
4c. County of Deeth: PRINCE GEORGES

Funeral Director

5. Social Security Number: ~~221~~-31-8719 213
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthdey)*: 42 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: Sept.14,1959
9. Birthplece *(State or Foreign Country)*: Sierra Leone

Usuel Residence of Decedent

10a. Slete: MARYLAND
10b. County: PRINCE GEORGES
10c. City, Town or Locetion: LANDOVER
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3503 DODGE PARK ROAD #T-2
10f. Zip Code: 20785
10g. Citizen of What Country?: AFRICA
11. Meritel Status: 1☐Never Merried 2☒Merried 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐Yes 2☒No If Yes, Give Yeer or Deles:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐Yes 2☒No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: BLACK
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: ASSISTANT MANAGER
16b. Kind of Business/Industry: FOOD SERVICE
17. Fether's Neme *(First, Middle, Last)*: MUSTAPHA KOROMA
18. Mother's Neme *(First, Middle, Maiden Surname)*: YANKIN KENU
19e. Informant's Neme/Reletionship *(Type, Print)*: DIANE KOROMA / WIFE
19b. Melling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3503 DODGE PARK RD.#T-2, LANDOVER, MARYLAND 20785
20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, cremetory or other plece)*: FORT LINCOLN CEMETERY — Dete: 12/27/01
20c. Locetion - City or Town, State: BRENTWOOD, MARYLAND
21. Signeture of Funerel Service Licensee: Shawn E Welker
22. Neme end Address of Feclity: FORT LINCOLN FUNERAL HOME INC. 3401 BLADENSBURG ROAD, BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart tellure. List only one cause on eech line. — Approximete Intervel Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in death): a. Gunshot Wound to back

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death?: 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed?: 1☒Yes 2☐No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?: 1☒Yes 2☐No

25. Wes cese referred to medical examiner?: 1☒Yes 2☐No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* AT SCENE

27. Menner of Deeth: 1☐Netural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*: 12/14/0
28b. Time of Injury: 0528 HRS
28c. Injury at Work?: 1☒Yes 2☐No
28d. Describe how injury occurred: subject shot
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: fast food esteblishment
28f. Locetion *(Street and Number or Rurel Route Number, City or Town, State)*: 9007 Annapolis Rood Lenham Mereland

29e. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2☒**Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Theodore M. King
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Yeer)*: DEC. 15, 2001
30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Yeer)*: DEC 27 2001
32. Registrer's Signeture: Barbara G. Sands

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42836

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Evelyn Louise Keyser	DECEMBER 27, 2001	7:05 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Hospital	Lanham	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
223 30 8682	1☐M 2☒F	78 Yrs.			Nov. 17, 1923	VA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	E.Riverdale	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6123 64th Ave., Apt. 3	20737	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	tape librarian	Nat'l. Aeronautics & Space Administration
	2		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Joseph M Phipps	Louise Edwards

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Herbert L. Keyser (husb.)	1902 Andrew Ct., Owings, MD 20736

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	12-28-01	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M. Michael Phipps	Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Carcinoma Lung with Metastases	1 year
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as e consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.
2☐ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Paul A. DeVore MD	D01852	DECEMBER 27 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL A. DeVORE MD 4203 QUEENSBURY Rd HYATTSVILLE MD 20782

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
DEC 28 2001	Geneva G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

KEYSER, EVELYN

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42837

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Ruth Barr Logan

2. Date of Death Month Day Year: December 27, 2001

3. Time of Death: 0720 M

4a. Facility Name *(If not institution, give street and number)*: Calvert Manor Healthcare Center

4b. City, Town, or Location of Death: Rising Sun

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 215-12-2906

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 10, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Port Deposit

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 160 South Main Street

10f. Zip Code: 21904

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Twelve Years; College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator

16b. Kind of Business/Industry: Logan's Wharf, Port Deposit, Maryland

17. Father's Name *(First, Middle, Last)*: Roland Barr

18. Mother's Name *(First, Middle, Meiden Surname)*: Ethel Gibson

19a. Informant's Name/Relationship *(Type, Print)*: Nancy L. Peters (daughter)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 19 High Street, Port Deposit, Maryland 21904

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Brookview Cemetery

Date: 12/30/01

20c. Location - City or Town, Stete: Rising Sun, Maryland

21. Signeture of Funeral Service Licensee: Thomas M. Patterson Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)

e. ALZHEIMER'S. Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnent in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnency 4☐ Pregnent at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D42800

29d. Date signed *(Month, Day, Year)*: 12/27/01

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: B Biondo 314 S. Main Ave, Fallston, Md 21078

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 28 2001

32. Registrar's Signature: Donna L. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend # 29c.Per Phys.
Amend #21.Per FH PGC 12-27-01 cr

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42838

LECOS, DEMOSTHENES

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Demosthenes William Lecos
2. Date of Death Month Day Year: Dec. 16, 2001
3. Time of Death: 8:16 PM
4a. Facility Name *(If not institution, give street and number)*: Prince George's County Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 517-30-6191
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov.23,1930
9. Birthplace *(State or Foreign Country)*: Montana

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Falls Church
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6311 Beachway Drive
10f. Zip Code: 22044
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 [ ] Never Msrried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952-1956
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 TH; College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed
16b. Kind of Business/Industry: Consulting

17. Father's Name *(First, Middle, Last)*: William Lecos
18. Mother's Name *(First, Middle, Maiden Surname)*: Diana Polites

19a. Informant's Name/Relationship *(Type, Print)*: Mary Anne Lecos (Spouse)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6311 Beachway Drive,Falls Church,Virginia,22044

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Quantico National Cemetery
Dete: 12/21/01
20c. Location - City or Town, State: Quantico,Virginia

21. Signature of Funeral Service Licensee: J. Mc Taggart
22. Name and Address of Facility: Everly Community Funeral Care, 6161 Leesburg Pk.,Falls Church,Va.22044

CR

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)
a. sudden cardiac arrest
Due to (or as a consequence of):
b. cardiovascular disease

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disesse or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Plece of Deoth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deoth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rebecca Ramney
29c. License number: VA 0101036684 ~~VA 0101036684~~
29d. Date signed *(Month, Day, Year)*: 12/18/01

30. Name and address of person who completed cause of deoth (Item 29b) (Type, Print): Rebecca Romney MD 201 N. Washington St Falls Church VA 22046

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001
32. Registrar's Signature: Brenda B. Spicer

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

15

DEC 2 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #20b&c PER FH G811 9/03/02 JH Amend #26. Per VR PGC 12-27-01 cr

Certificate of Death

Reg. No. 2001 42839

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Frank Law	December 18, 2001	305P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3609 CHIEFMARK ROAD	OWINGS MILLS	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
066-32-0011	1☒M 2☐F	62 Yrs.			06-29-1939	Thomasville, GA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Hyattsville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4829 Lasalle Rd.	20782	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Metro Driver	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Willie Lundy	Willie Mae Law

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Phyllis Law/ Wife	4829 Lasalle Rd. Hyattsville, MD 20782

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MOUNT OLIVET CEMETERY ~~Ft. Lincoln~~	12-22-01	WASHINGTON, DC. 20002 ~~Brentwood, MD~~

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. D. Marshall	JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☑Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☑Residence 8☑Other (Specify) Son's Home

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ E.P. Williamson MD	D11171	DECEMBER 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E.P. WILLIAMSON 3933 ST JOHNS LANE ELLICOTT CITY MARYLAND 21042

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Barbara G. Franks

DHMH 17 Rev 1/2001

ORIGINAL

DEC 8 1 5001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42840

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WIESLAW LUBEK
2. Date of Death (Month, Day, Year): December 22, 2001
3. Time of Death: 10:00AM
4a. Facility Name (If not institution, give street and number): 1402 Houndhill Court
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-15-2976
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 48 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 26, 1953
9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1402 Houndhill Court
10f. Zip Code: 21114
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self employed
16b. Kind of Business/Industry: Marine Brokerage

17. Father's Name (First, Middle, Last): Stanislaw Lubek
18. Mother's Name (First, Middle, Maiden Surname): Stanisława Wysocki

19a. Informant's Name/Relationship (Type, Print): Jadwiga Lubek Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1402 Houndhill Ct., Crofton, Md. 21114

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery
Date: 12-28-01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature] Beall
22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC RENAL CELL CANCER — 1 1/2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D33759
29d. Date signed (Month, Day, Year): 12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARIF HUSSAIN, MD 22 S. GREENE ST., BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

(5)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42841

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bertha Synek Libersky

2. Date of Death Month Day Year: December 23, 2001

3. Time of Death: 4:20 P M

4a. Facility Name *(If not institution, give street and number)*: Magnolia Hall Nursing Home

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 100-20-9720

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 2, 1925

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Md

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 200 Morgnec Road

10f. Zip Code: 21620

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: William Synek

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Synek

19a. Informant's Name/Relationship *(Type, Print)*: Joanne Libersky (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 711 Double Creek Road Chestertown, Md. 21620

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removef from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Libersky Farm

Date: 12/27/01

20c. Location - City or Town, Stete: Chestertown, Md.

21. Signeture of Funeral Service Licensee: Kirk J. Fellows

22. Name and Address of Facility: Fellows, Heffenbein & Newnam Funeral Home, P.A 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DEHYDRATION — 10 days

Due to (or as a consequence of):

Sequentielly fist conditions, if eny, feeding to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. FAILURE TO THRIVE — 1 month

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the pest 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent et time of deeth 5☐Other *(specify)* 9☐Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contnbuting to death but not resulting in the underlying ceuse given in Part I.

QUADRIPLEGIA
RHEUMATOID ARTHRITIS
CONGESTIVE HEART FAILURE
DEPRESSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Wes cese referred to medical exeminer? 1☐Yes 2☒No

28. Plece of Death *(Check only one)*

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece of Fnjury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as steted. 2☐**Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: John R Noble

29c. License number: D0041587

29d. Date signed *(Month, Day, Yeer)*: 12/24/2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Dr. Helen A. Noble, M.D. 122 Speer Road Suite. 5 Chestertown, Md.,21620

State Registrar

31. Date filed *(Month, Day, Yeer)*: DEC 26 2001

32. Registrar's Signature: M. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42842

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Yuannan Lin

2. Date of Death (Month, Day, Year): December 22, 2001

3. Time of Death: 11:18 PM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-82-7277

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 9, 1943

9. Birthplace (State or Foreign Country): Taiwan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: North Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12711 Young Lane

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson

18b. Kind of Business/Industry: Automobile

17. Father's Name (First, Middle, Last): Mu-King Lin

18. Mother's Name (First, Middle, Maiden Surname): Bing-Chu Won

19a. Informant's Name/Relationship (Type, Print): Michael Lin/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3404 Diehl Court, Falls Church, Virginia 22041

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium

Date: December 29, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: Minutes

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Liver Cancer Stage IV

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D54635

29d. Date signed (Month, Day, Year): December 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Cetta, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42843

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN D. McCAIN, SR.

2. Date of Death (Month, Day, Year): December 20, 2001

3. Time of Death: 12:39 A.M.

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 237-32-2063

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 17, 1923

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 12213 Kings Arrow Street

10f. Zip Code: 20721

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: GOvernment Printing Office

17. Father's Name (First, Middle, Last): Bernie Mc Cain

18. Mother's Name (First, Middle, Maiden Surname): Anna Beatrice Massey

19a. Informant's Name/Relationship (Type, Print): Mr. John D. Mc Cain, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12213 KingsArrow Street Mitchellville, Maryland 20721

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery

Date: 12/27/01

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Janet C. Anderson

22. Name and Address of Facility: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Intestinal obstruction — 1 DAy.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D46478

29d. Date signed (Month, Day, Year): 12.20.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suresh A. Patel MD 7501 Surratts Rd. Clinton, MD 20735

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12/20/01 @ 1234

McCain, John

SP

(1)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42844

Physician /Medical Examiner

1. Decedant's Name *(First, Middle, Last)*: Margo Moore

2. Dete of Deeth — Month: December Day: 22, Year: 2001

3. Time of Death: 1:30am

4e Facility Neme *(If not institution, giva street and number)*: Bradford Oaks Adventist Nsg.Home

4b. City, Town, or Location of Death: Clinton

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 579-56-7270

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 6, 1942

9. Birthplace *(Stete or Foreign Country)*: Wash, D.C

Usuel Residance of Decedent

10a. State: Md.

10b. County: P.G.

10c. City, Town or Location: Capital Hgts.

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 4801 Pistachio Lane

10f. Zip Code: 20743

10g. Citizen of What Country?: U.SA.

11. Marital Stetus: 1☐Nevar Married 2☐Merried 3☐Widowed 4☒Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12); College (1-4or 5+): 4Years

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: D.C.School

17. Father's Neme *(First, Middle, Last)*: William Edgar Burrell

18. Mother's Neme *(First, Middle, Meiden Sumame)*: Mary Johnson

19e. Informent's Neme/Reletionship *(Type, Print)*: Michelle Stover-Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4801 Pistachio Lane Capital Hgts, Md. 20743

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Othar *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Ft. Lincoln Cemetery

Dete: 12-27-01

20c. Location - City or Town, Stete: Brentwood, Md.

21. Signature of Funerel Servica Licensee: Janet C. Anderson

22. Neme end Address of Facility: 5635 Eads St, N.E. Dunn & Sons Funeral Services

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)

a. CARCINOMA of The BREAST — Mos

Due to (or es a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☒Nursing Home 5☐Residenca 8☐Other *(Specify)*

27. Menner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dele of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier:

29c. License number: D19431

29d. Date signed *(Month, Day, Year)*: 12/27/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Frank M. Ryan MD 11701 Gunpowder Rd #203 Ft. Washington MD 20744

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 28 2001

32. Registrer's Signeture: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42845

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Wilfred Mattadeen	December 17, 2001	5:30P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George Hospital	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
108-58-4595	1☒M 2☐F	56 Yrs.			Oct. 23 1945	Trinidad

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Landover	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1927 Palmer Park Rd.	20785	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Correctional Officer	Government

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Joseph Manburg	Winifred Mattadeen

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Avryl Mattadeen/ Wife	1927 Palmer Park Rd. Landover, MD 20785

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Mt. Olivet Cemetery	12-24-01	Washington

21. Signeture of Funeral Service Licensee	22. Name and Address of Feciliby
▶ L. D. Marshall	JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth)

a. Congestive Heart Failure — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet inflicted events resulting in death) Last

b. Coronary Artery Disease — Years

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Diabetes Mellitus

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical exeminer? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify)	28I. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Surinder Singh	D28920	12-27-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surinder Singh 7319A Hanover Parkway Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
DEC 27 2001	Bonnie B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 2 7 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42846

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alberta V. McQueen

2. Date of Death (Month, Day, Year): December 15, 2001

3. Time of Death: 1:20 PM

4a. Facility Name *(If not institution, give street and number)*: 730 Capital Heights Blvd

4b. City, Town, or Location of Death: Capital Heights

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 243-42-3108

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 25, 1929

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Capital Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 730 Capital Heights Blvd

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic Worker

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: James E. Parks

18. Mother's Name *(First, Middle, Maiden Surname)*: Rena M. Cochrance

19a. Informant's Name/Relationship *(Type, Print)*: Juanita M. Tibbs- Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 730 Capital Heights Blvd Capital Heights MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery

Date: 12-22-01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. END Stage LUNG CANCER — 1yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen Reilly MD

29c. License number: D54749

29d. Date signed *(Month, Day, Year)*: 12 16 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4805 Benson Avenue, Baltimore, MD 21227

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42847

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Seymour Harry Meiselman

2. Date of Death (Month, Day, Year): December 26, 2001

3. Time of Death: 3:45 P.M.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 014-14-8682

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May30,1919

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10a. Street and Number: 5116 Parklawn Terrace, #103

10f. Zip Code: 20852

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Project Manager

16b. Kind of Business/Industry: Government Defense Department

17. Father's Name (First, Middle, Last): Charles S. Meiselman

18. Mother's Name (First, Middle, Maiden Surname): Sadie Wickner

19a. Informant's Name/Relationship (Type, Print): Bessie Meiselman - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852: 5116 Parklawn Terrace, #103 Rockville, Maryland

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King David Memorial Gdn.

Date: 12/28/2001

20c. Location - City or Town, State: Falls Church, Va.

21. Signature of Funeral Service Licensee: Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cerebral Hemorrhage — 9 days

Due to (or as a consequence of): b. Warfarin Therapy — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Atrial Fibrillation — 1 year

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven Warach

29c. License number: D0054355

29d. Date signed (Month, Day, Year): DEC 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN WARACH MD NATIONAL INST HEALTH 10 Center Drive BETHESDA Md. 20892

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Barbara B. Spahr

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

20

DEC 17 2001

Unknown 01-340
CJ SHARLENE MANSFIELD
01-6950-033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42848

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charlene Mansfield
2. Date of Death Month / Day / Year: December 09 2001
3. Time of Death: 02:55 A.M.

4a. Facility Name *(If not institution, give street end number)*: Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-72-5936
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12-21-1954
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1359 C St. S.E.
10f. Zip Code: 20003
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 4yrs
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Charles G. Mansfield
18. Mother's Name *(First, Middle, Maiden Surname)*: Thelma Moyer

19a. Informant's Name/Relationship *(Type, Print)*: Thelma Mansfield/Mother
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 7316 Lois Lane, Lanham, MD 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery
Date: 12/17/01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: K. D. Mansfield
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Multiple Stabbed Cutting Wounds
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 12/9/01
28b. Time of Injury: unk M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subjects stabbed and cut
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Found on street
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*: 23rd St SE / Savannah Washington DC

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: for
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: December 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 24 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42849

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cathy Marie Myers
2. Date of Death (Month, Day, Year): December 31, 2001
3. Time of Death: 1400 M
4a. Facility Name (If not institution, give street and number): 300 Haddaway Drive Apt. 9E
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 352-48-6906
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 48 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 2, 1953
9. Birthplace (State or Foreign Country): Wisconsin

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State: Ill.
10b. County: Champaign
10c. City, Town or Location: Champaign
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 609 Teal Cove
10f. Zip Code: 61821
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert E. Schwanke
18. Mother's Name (First, Middle, Maiden Surname): Dolores Vogel

19a. Informant's Name/Relationship (Type, Print): Glen Dale Myers (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Teal Cove Champaign, Illinois 61821

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ches. Cremation Center
Date: 1/2/2002
20c. Location - City or Town, State: Stevensville, Md

21. Signature of Funeral Service Licensee: Jason Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — Approximate Interval Between Onset and Death: 3 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): HTN
c. Due to (or as a consequence of): SLEEP APNEA
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CVA
OBESITY

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Patricia Shanahan
29c. License number: D36054
29d. Date signed (Month, Day, Year): 12/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICIA SHANAHAN DO SPEER RD CHESTERTOWN MD 21620

State Registrar

31. Date filed (Month, Day, Year): JAN 02 2002
32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42850

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth C. Myers
2. Date of Death (Month, Day, Year): December 22, 2001
3. Time of Death: 5:45P M
4a. Facility Name (If not institution, give street and number): 10760 Flatland Road
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 215-36-0112
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): April 5, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10760 Flatland Road
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Henry Clothier
18. Mother's Name (First, Middle, Maiden Surname): Ruth Middleton Clothier

19a. Informant's Name/Relationship (Type, Print): Bill Myers (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11955 St. James Road Chestertown, Md. 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chester Cemetery
Date: 12/28/01
20c. Location - City or Town, State: Chester, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Dehydration — Approximate Interval Between Onset and Death: 4 days
Due to (or as a consequence of):
b. Sacral decubitus — 2 months
Due to (or as a consequence of):
c. Morganella urinary tract infection — 6 wks.
Due to (or as a consequence of):
d. Rheumatoid arthritis — 10 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HTN, Atrial fibrillation, chronic renal insufficiency, chronic anemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D51735
29d. Date signed (Month, Day, Year): 12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Frederick Delboy 6602 Church Hill Road Suite 200 Chestertown, Md. 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42851

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Ann Morris

2. Date of Death (Month, Day, Year): December 13, 2001

3. Time of Death: 12:30 A M

4a. Facility Name (If not institution, give street and number): Chestertown Nursing & Rehab. Center

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 221-26-0384

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 2, 1941

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Md

10b. County: Kent

10c. City, Town or Location: Betterton

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 119 1st Avenue

10f. Zip Code: 21610

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Teller

16b. Kind of Business/Industry: Peoples Bank

17. Father's Name (First, Middle, Last): Edwin Theodore Greenplate

18. Mother's Name (First, Middle, Maiden Surname): Sarah Elizabeth Foster

19a. Informant's Name/Relationship (Type, Print): Samuel C. Morris (Husband)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): P O Box 214 Betterton, Md. 21610

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Crumpton Cemetery

Date: 12/17/2001

20c. Location - City or Town, State: Crumpton, Maryland

21. Signature of Funeral Service Licensee: Fellows, Helfenbein & Newnam

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Astrocytoma of the Brain — >4years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown

23d. Data of delivery Month Day Year

Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was cese referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

26b. Time of Injury M

26c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: MD

29c. License number: D0051786

29d. Date signed (Month, Day, Yeer): 12-13-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW S. FERGUSON MD . 120 SPEER RD CHESTERTOWN MD 21620

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 14 2001

32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42852

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Rose Vaccaro McGovern	December 30, 2001	10:30 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
450 Carriage Lane	Huntingtown	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579 14 5842	1☐M 2☒F	90 Yrs.			Aug. 9, 1911	Wash., DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Calvert	Huntingtown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
450 Carriage Lane	20639	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	supervisor	United States Census Bureau

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Pasquale Vaccaro	Josephine Lobanco

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alessia M. O'Dell (granddaug.)	same as 10af above

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	12-31-01	Alexandria, VA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE STROKES — Approx. Interval: YEARS

Due to (or as a consequence of):
b. ATHEROSCLEROTIC VASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D26358	DEC. 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN H. WEIGEL MD - PRINCE FRED PRICE, MD - 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 02 2002	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42853

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jessie Lee Manglass
2. Data of Death Month Day Year: December 26, 2001
3. Time of Death: 1:05 PM
4a. Facility Name (If not institution, give street and number): Manor Care Chevy Chase
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 117-38-4768
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 26, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: New York
10b. County: Dutchess
10c. City, Town or Location: Beacon
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 18 Robinson Street
10f. Zip Code: 12508
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Charles S. Maddox
18. Mothar's Name (First, Middle, Maiden Surnama): Sarah E. Pruitt

19a. Informant's Name/Relationship (Type, Print): Joyce Fekkak/Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5321 Trailway Drive, Rockville, Maryland 20853

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Crematory
Date: Dec. 31, 2001
20c. Location - City or Town, State: Newburgh, New York

21. Signature of Funeral Service Licensee: M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Daeth

Immediate Cause (Finel diseese or condition resulting in death)
a. Cardiopulmonary Arrest — 5 Weeks

Due to (or as a consequence of):
b. Metastatic Lung Cancer — Years

Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c. Metastatic Breast Cancer — Years

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Chronic Pulmonary Lung Disease

23b. Did tobacco uee contribute to the cause of death? 1☒ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medicel examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier:
29c. License number: D19609
29d. Date signed (Month, Day, Year): December 27, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Raman R. Tuli, M.D. 10810 Darnestown Road Suite 202, Gaithersburg, Maryland 20878

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Deana B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42854

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
George Forbes Mann	December 22, 2001	3:35am M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
18405 Bishop Stone Court	Montgomery Village	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-19-5626	1☒M 2☐F	67 Yrs.			Sept. 14, 1934	Scotland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Montgomery Village	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
18405 Bishop Stone Court	20886	England

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Scientist	Viriology

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Mann	Mary Findley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886
Beulah McClanahan (Wife)	18405 Bishop Stone Court, Montgomery Village, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Forest Oak Cemetery	12/28/2001	Gaithersburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert H. DeVol	DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. C.O.P.D.	Years
	Due to (or as a consequence of): c. Cirrhosis (Alcohol)	Years
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction, High Blood Pressure, Duodenal Ulcer

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Eric Brodsky M.D.	54299	December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric Brodsky, M.D. 15215 Shady Grove Road #303, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42855

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
FRANCES	M.	MARK	DECEMBER 21, 2001	7:17 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WASHINGTON ADVENTIST HOSPITAL	TAKOMA PARK	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
147-24-7773	1☐M 2☒F	81 Yrs.			JAN 15, 1920	CZECHLOVIKIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	SILVER SPRING	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11207 LOMBARDY ROAD	20901	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	LIBRARIAN	FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOSEPH MUNZ	KARLA CHARVAT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JEROME MARK-HUSBAND	11207 LOMBARDY ROAD SILVER SPRING, MD 20901

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	JUDEAN MEMORIAL GARD	12/26/01	OLNEY, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC
1170 ROCKVILLE PIKE ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): End stage Congestive Heart Failure	
	c. Due to (or as a consequence of): Valvular heart disease	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency
pneumonia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ V. NEGUSSIE MD	D45471	Dec. 22nd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YEHENIS NEGUSSIE, MD 4404 Gunsburg Rd Rivrdale, MD 20737

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	▶ Geneva G. Sanks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42856

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cheng-Lu Mao
2. Date of Death (Month, Day, Year): December 21, 2001
3. Time of Death: 7:00 A M
4a. Facility Name (If not institution, give street and number): 14200 Amberleigh Terrace
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 473-92-7575
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 21, 1912
9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 14200 Amberleigh Terrace
10f. Zip Code: 20905
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Der-Hsin Mao
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Karin Ashe / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4717 Rippling Pond Drive; Fairfax, Virginia 22033

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Memorial Park | Date: 12/29/01
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: Richard Turner
22. Name and Address of Facility: Hines-Rinaldi Funeral Home Inc. 11800 New Hampshire Ave; Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Chronic Obstructive Pulmonary Disease — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the pest 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown
23d. Date of delivery (Month, Day, Year)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Arteriosclerotic Heart Disease

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residenca 6☐Other (Specify)
27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medicat Examiner:** On the basis of examination and/or investigatlon, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Bernadette Soong MD
29c. License number: D0013550
29d. Date signed (Month, Day, Yeer): 12/26/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bernadette Soong MD 1104 Spring Street, Suite 200; Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. CE

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42857

AMEND IYEM#17&18 PER INFMNT. G803 1-25-02 JB

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Eleanor P McAuliffe

2. Dete of Deeth — Month: December Dey: 21 Year: 2001

3. Time of Death: 6:30am

4e. Fecility Neme (If not institution, giva streat and number): Wilson Health Care Center

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-46-7727

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 96 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): May 19, 1905

9. Birthplaca (State or Foreign Country): Washington D.C.

Usual Residance of Decedant

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 301 Russell Avenue

10f. Zip Code: 20877

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): ; College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Neme (First, Middle, Last): JOHN J. McAULIFFE ~~Silvio Giovanetti~~

18. Mother's Neme (First, Middle, Meiden Surneme): ALICE GANNON ~~Emilia Savarese~~

19e. Informant's Neme/Relationship (Type, Print): Janet M. Clark/ Niece

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 889 Holly Dr., W., Annapolis, MD. 21401

20e. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cametery, cremetory or other place): Metropolitan Crematory

Date: 12/21/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael Allen

22. Nama and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)

e. Cerebral Vascular Accident — 10 days

Due to (or es e consequence of):

b. Myocardial Infarction — 10 days

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

Due to (or es e consequenca of):

c.

Dua to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Normal Pressure Hydrocephalus

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Straet end Number or Rurel Routa Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at tha time, dete end pleca, and due to the ceuse(s) end menner steted.

29b. Signatura and title of certifier: Priscilla Callahan-Lyon

29c. Licensa number: 041794

29d. Data signed (Month, Day, Year): December 21, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Priscilla Callahan-Lyon, MD 911 Gaithersburg, MD — 911 Russell Avenue

State Registrar

31. Data filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42858

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Robert H. McCallam, Jr.

2. Dete of Deeth — Month: December; Dey: 26; Yeer: 2001

3. Time of Death: 5:10 am

4a Facility Neme *(If not institution, give street end number)*: Bedford Court Nursing Home

4b. City, Town, or Location ot Deeth: Silver Spring

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 578-09-9420

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthdey)*: 86 Yrs.

If Under 1 Year: Months: ; Deys:

If Under 24 Hrs.: Hours: ; Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: Feb 7, 1915

9. Birthplece *(Stete or Foreign Country)*: New Jersey

Usual Residence ot Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14604 Georgia Avenue

10f. Zip Code: 20853

10g. Citizen ot What Country?: USA

11. Merital Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII

13. Was Decedent ot Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Reca - American Indien, Bteck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): ; College (1-4or 5+): 2

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Printer

16b. Kind of Business/Industry: Newspaper Printing

17. Fether's Neme *(First, Middle, Last)*: Robert H. McCallam, Sr.

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Ethel May Harman

19a. Intormant's Neme/Reletionship *(Type, Print)*: Barbara J. Steed / Daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 14604 Georgia Avenue, Rockville, MD 20853

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece ot Disposition *(Name of cemetery, crematory or other piece)*: Metropolitan Crematory — Dete: Dec 27 2001

20c. Location - City or Town, Stete: Alexandria , VA

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Neme end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GF

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or respiratory errest, shock, or heart tailure. List *only* one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in deeth): e. Pneumonia — days

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last

b.

Due to (or es e consequenca ot):

c.

Due to (or es e consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveilable prior to completion ot cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place ot Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury: M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, terrn, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 + 1yr.

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end pleca, and dua to the ceuse(s) end manner steted.

29b. Signeture end title ot certifier: Gabriel A Berrebi

29c. License number: 30692

29d. Date signed *(Month, Dey, Yeer)*: December 26, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Gabriel A. Berrebi, MD 15225 Shady Grove Road #305, Rockville, MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 27 2001

32. Registrer's Signeture: Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42859

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Bradley McCloskey
2. Date of Death Month Day Year: December 22, 2001
3. Time of Death: 12:40A.M.
4a. Facility Name *(If not institution, give street and number)*: National Lutheran Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 162-03-3412
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 17, 1912
9. Birthplace *(State or Foreign Country)*: Montana

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4618 Norwood Drive
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper
16b. Kind of Business/Industry: Sears Roebuck & Co.

17. Father's Name *(First, Middle, Last)*: James P. Bradley
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Gallagher

19a. Informant's Name/Relationship *(Type, Print)*: Mary Lou McCalley/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4618 Norwood Drive Chevy Chase, Maryland 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: Dec. 29, 2001
20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: John F. DeVol
22. Name and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash.D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Aspiration Pneumonia	2 days
Due to (or as a consequence of): b.	Gastroesophageal reflux	1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Alzheimer's Dementia	7 years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of Certifier: Schemm MD
29c. License number: D36618
29d. Date signed *(Month, Day, Year)*: December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher M. Schemm, M.D. 10529 Farnham Dr. Bethesda, MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42860

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH B. McDANIEL

2. Date of Death: Month December Day 25 Year 2001

3. Time of Death: 6:05 AM

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 023-24-7763

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 13, 1932

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Sandy Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 18505 Marden Lane

10f. Zip Code: 20860

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator

16b. Kind of Business/Industry: U. S. Government

17. Father's Name (First, Middle, Last): Joseph B. McDaniel, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Eva I. Fountain

19a. Informant's Name/Reletionship (Type, Print): John Clark / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 431 Gaither St., Gaithersburg, Maryland 20877

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cem.

Date: 12/31/01

20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: Muriel N. Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one causa on each line.

Approximata Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. METASTATIC NONSMALL CELL LUNG CANCER — MONTHS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) N/A 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

EMPHYSEMA
HYPERTENSION
CORONARY ARTERY DISEASE

23a. Did tobacco usa contribute to the cause of daath? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of daath? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D42403

29d. Date signad (Month, Day, Yaar): DECEMBER 25, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): RAJ MATHUR 106 IRVING STREET, WASHINGTON D.C 20010

State Registrar

31. Data filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Geneva B. Scarlett

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42861

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Angelina Murgo
2. Date of Death Month / Day / Year: December 26, 2001
3. Time of Death: 6:30am
4a. Facility Name *(If not institution, give street end number)*: Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 064-03-0615
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 26,1913
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Laytonsille
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19609 Hoover Farm Drive
10f. Zip Code: 20882
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Brancasio LoTurco
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Rosaria D'Agostino

19a. Informant's Neme/Relationship *(Type, Print)*: Anthony Murgo (Son)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 19609 Hoover Farm Dr. Laytonsville, Md. 20882

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: St. Charles Cemetery
Dete: Dec.29, 2001
20c. Location - City or Town, State: Farmingdale,N.Y.

21. Signature of Funeral Service Licensee: ▶ Curtis. E Day
22. Name end Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or compiicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finei diseese or condition resulting in deeth)
a. Congestive Cardiomyopathy — years

Due to (or es a consequence of):
b. Pulmonary Hypertension — years

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last
Due to (or es e consequence of):
c. Atrial Fibrillation — years

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶ Priscilla Callahan-Lyon
29c. License number: D41794
29d. Date signed *(Month, Day, Year)*: December 26, 2001

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): Priscilla Callahan-Lyon, MD 911 Russell Ave Gaithersburg, MD 20879

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42862

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JOHN	CLIFTON	MURRY	Dec.	21,	2001	8:50 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Collingswood Nursing Home	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-94-9090	1☒M 2☐F	82 Yrs.					Oct. 19, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Wheaton	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3400 Floral St	20902	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		Laborer	Farm

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Murry Sr.	Mary Nelson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Norma Stribling/ Niece	12039 Crimson Ln Silver Spring, MD 20904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Norbeck Mem Park	12/29/2001	Olney, MD

21. Signature of Funeral Service Licensee: Sonya L. Snowden

22. Name and Address of Facility: Snowden Funeral Home P.A. 246 N Washington St Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Cerebrovascular Accident

Due to (or as a consequence of):

d. Multi-infarct Dementia

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
A. Seidman MD	D37801	Dec. 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aimee Seidman, M.D. 11906 Darnestown Rd., Gaithersburg, MD 20878

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42863

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Julia	Moore	December 17, 2001	2140 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-34-9933	1☐ M 2☒ F	69 Yrs.			Nov. 14, 1932	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Philadelphia Co.	Philadelphia	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2749 N. Taylor Street	19132	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	+2	clerical	Blue Cross/Blue Shield of Pennsylvania

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Randolph Hudson	Lola Holland

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Stanford Moore/husband	2749 N. Taylor Street - Philadelphia, PA 19132

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Coolspring Church Cem	12/22/2001	Girdletree, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Patricia A Jolley	1213 Jersey Road - Salis., MD 21801 JOLLEY MEMORIAL CHAPEL

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Bladder Cancer	one year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D051359.	December 18th 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
USHA NATESAN 106 PINE BLUFF ROAD SALISBURY, MD 21801.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Julia Moore 218-34-9933

10 DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42864

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Victor Ray Nolan
2. Date of Death (Month, Dey, Yaer): December 18, 2001
3. Time of Death: 7:43am
4a. Facility Name *(If not institution, give street and number)*: Prince George Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 577-80-4805
6. Sex: 1☒M 2☐F
7. Aga *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: 11-25-1954
9. Birthplaca *(Stete or Foreign Country)*: Wash,D.C.

Usuel Residence of Decedent

10a. State: D.C.
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 4233 Blaine St,N.E.
10f. Zip Code: 20019
10g. Citizen of Whet Country?: U.S.A.
11. Maritai Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☒Yas 2☐No If Yes, Give Yeer or Detes: 1973
13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐Yes 2☒No *Specify:*
14. Race - Amarican indian, Bleck, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grada completed)*: Elementery/Secondery (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Police
16b. Kind of Business/Industry: DHL
17. Father's Neme *(First, Middle, Last)*: Ernest Nolan
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Enola Mae Harrison
19e. Informent's Name/Relationship *(Type, Print)*: Mary Nolan-Wife
19b. Meiling Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 4233 Blaine St,N.E.20019
20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stata 4☐Donetion 5☐Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other piece)*: Quanitco National — Dete: 12-26-01
20c. Location - City or Town, Steta: Quanitco,Va.
21. Signature of Funeral Service Licensee: Janet C. Anderson
22. Name end Address of Fecility: Dunn & Sons 5635 Eads St,N.E.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. — Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sickle Cell Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Cardiac Arrest — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d. — Due to (or as a consequence of):

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of causa of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residenca 8☐Other *(Specify)*

27. Manner of Death: 1☒Neturai 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of injury - At home, ferm, streat, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end manner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature]
29c. License number: DC 11255
29d. Date signed *(Month, Day, Year)*: 12/18/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr.Benjamin Blatt 2150 Pennsyvania Ave N.W.

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 26 2001
32. Registrar's Signeture: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(4)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42865

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE NATHAN
2. Date of Death: Month 12 Day 20 Year 2001
3. Time of Death: 5PM.
4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY,
4c. County of Death: PRINCE GEORGE.

Funeral Director

5. Social Security Number: 213-02-0694
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-19-1930
9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Greenbelt
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6705 Springshire Way
10f. Zip Code: 20770
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4 Yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Technician
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Gangaram Nathan
18. Mother's Name (First, Middle, Maiden Surname): Rachel Daniel

19a. Informant's Name/Relationship (Type, Print): Sheila Nathan/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6705 Springshire Way Greenbelt, MD 20770

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cem.
Date: 12/23/01
20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: K.E. Wilk
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. MASSIVE INTRACRANIAL BLEED
Due to (or as a consequence of):
b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERLIPIDEMIA
DIABETES MELLITUS
PACEMAKER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D0043662
29d. Date signed (Month, Day, Year): 12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM BOYCE PG HOSPITAL, CHEVERLY MD 20785

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42866

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SETH D. NELSON
2. Date of Death (Month, Day, Year): DECEMBER 24, 2001
3. Time of Death: 8:19 M

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALL'S TOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-68-6060
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 29, 1948
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 665 Sykesville Road
10f. Zip Code: 21784
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Joseph N. Nelson
18. Mother's Name (First, Middle, Maiden Surname): Lillian Stern

19a. Informant's Name/Relationship (Type, Print): Michael P. Nelson/Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 Paulsboro Drive, Rockville, Maryland 20850

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium
Date: December 27, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANOXIC ENCEPHALOPATHY
DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24e. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D51245
29d. Date signed (Month, Day, Year): DECEMBER 24, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): SAJID SHARIF NORTHWEST HOSPITAL - RANDALL'S TOWN, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42867

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
MYRNA	LOY	NEWTON	DECEMBER 20 2001	1717 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
502-28-7748	1☐M 2☒F	65 Yrs.			SEPT. 5, 1936	MINNESOTA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	WICOMICO	SALISBURY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1018 BEAGLIN PARK DR. APT. 102	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
THEODORE T. SCHOSTAG	MABEL MAILLOUX

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GERALD E. NEWTON HUSBAND	1018 BEAGLIN PARK DR. APT 102 SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CREMATORY OF DELMARVA	12/22/2001	DELMAR, DE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ B. Reed Lynn CFSP	BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular Accident

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	H0052410	12/21/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

SIMONA ENG, M.D. 100 E CARROLL ST. SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 2001	▶ Penina G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MYRNA NEWTON 502 28 7748

6 DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42868

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys G. Nichols
2. Date of Death (Month, Day, Year): Dec. 12, 2001
3. Time of Death: 3:25 pm
4a. Facility Name *(If not institution, give street and number)*: Heritage Harbor Health Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-42-0652
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 30, 1914
9. Birthplace *(State or Foreign Country)*: MI

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Millersville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 325 Cool Ridge Court
10f. Zip Code: 21108
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Morrison Gray
18. Mother's Name *(First, Middle, Maiden Surname)*: Robina Gibb

19a. Informant's Name/Relationship *(Type, Print)*: Douglas Nichols/ Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 325 Cool Ridge Court, Millersville, MD 21108

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Metro Crematory
Date: Dec. 14 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas E. [illegible]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cerebral vascular accident — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N. Tavakoli M.D.
29c. License number: D41978
29d. Date signed *(Month, Day, Year)*: 12-13-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nader Tavakoli 4000 Mitchellville Rd A312 Bowie MD 20716

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 17 2001
32. Registrar's Signature: [illegible]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42869

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary S. Norcio

2. Date of Death Month Dey Yaer: December 13, 2001

3. Time of Death: 12:10 PM

4a. Facility Name *(If not institution, give street and number)*: Annapolis Nursing & Rehabilitation Ctr.

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-38-7343

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: May 22, 1909

9. Birthplece *(Stete or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1852 St. Margarets Road

10f. Zip Code: 21401

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yas 2☒ No *Specify:*

14. Rece - American Indien, Black, Whita, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest greda completad)*: Elementery/Secondery (0-12): 11th | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Federal Government

17. Father's Neme *(First, Middle, Last)*: Daniel Sullivan

18. Mother's Name *(First, Middle, Maiden Surneme)*: Mary Liston

19a. Informent's Name/Reletionship *(Type, Print)*: Anthony F. Norcio/ Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1852 St. Margarets Rd. Annapolis, MD 21401

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 12-14-01

20c. Location - City or Town, Stete: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ Robert P. Kalas

22. Name end Addrass of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiretory arrast, shock, or heert failure. List only one ceuse on eech line.

Approximate intervel Between Onset end Death

Immediete Ceuse (Finel disaese or condition resulting in deeth)

a. MYOCARDIAL INFARCT — 6 HRS

Due to (or es a consequence of):

b. ARTERIOSCLEROSIS — 15 YEARS

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last

Due to (or es a consequence of):

c. HYPERTENSION — 30 YEARS

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminar? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: ▶ Walter Hepner

29c. License number: D23450

29d. Date signed *(Month, Dey, Year)*: 12/14/01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Walter Hepner, M.D. 11403 Kronhill Drive Owings Mills, MD 21117

State Registrar

31. Deta filed *(Month, Day, Year)*: DEC 17 2001

32. Registrar's Signeture: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42870

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Leon A. Nasteff	December 14 2001	2:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Eldercare Spa Creek	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-09-9882	1☒ M 2☐ F	85 Yrs.			February 13, 1916	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
106 E. Bay View Drive	21403	U.S.A.

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1945-1946	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Engineer	Telephone Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Anastas Nasteff	Emma Thiele

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Virginia C. Nasteff/wife	106 E. Bay View Drive Annapolis, MD 21403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Baltimore Crematory	12/19/01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael J. Sloan	John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Due to (or as a consequenca of): — 6m

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown	
24a. Was an autopsy performed? 1☐ Yes 2☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case relerred to medical examiner? 1☐ Yes 2☒ No	28. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ Gary J. Sprague, MD	032036	12/15/2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Gary J. Sprague, MD 2108 N. Donato Drive Ches. MD 21619

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 17 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend # 26.Per Phys.PGC 12-28-01 cr

Certificate of Death

Reg. No. 2001 42871

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lendell W. Outlaw
2. Date of Death: Month Dec. Day 25 Year 2001
3. Time of Death: 8:56 AM
4a. Facility Name (If not institution, give street and number): 12907 Mayflower Lane
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 244-01-2352
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 12, 1914
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: VA
10b. County:
10c. City, Town or Location: Virginia Beach
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 916 Charnell Drive Unit 203
10f. Zip Code: 23451
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Crane Operator
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Harvey Outlaw
18. Mother's Name (First, Middle, Maiden Surname): Budwood Smallwood

19a. Informant's Name/Relationship (Type, Print): Deloris O. Hoggard-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12907 Mayflower lane, Bowie, MD 20720

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Roosevelt
Date: 12/28/01
20c. Location - City or Town, State: Chesapeake, VA

21. Signature of Funeral Service Licensee: ▶ Nelson E Greene
22. Name and Address of Facility: Greene Funeral Home, INC. 814 Franklin St. Alexandria, VA 22314

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finaf disease or condition resulting in death)	a. Metastic Lung Cancer, uncertain primary	3 months
Due to (or as a consequeqce of):		
Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or es a consequence of):		
	c.	
Due to (or es a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an eutopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medicaf examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Daughter's Residence

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ Kris E. Kahn MD
29c. License number: MD 30946
29d. Date signed (Month, Day, Year): December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kris E Kahn MD 1160 Varnum St. NE Suite 021 Washington DC 20017

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Gendra D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CR

7

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42872

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Charles Wilson O'Berry			December 25, 2001	2:30 AM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
4924 Baffin Bay Lane	Rockville		Montgomery	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-22-4171	1[X] M 2[ ] F	76 Yrs.			Nov 11, 1925	Michigan

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4924 Baffin Bay Lane	20853	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: 1943-1946	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Printer	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Emory Lewis O'Berry	Isabelle Elizabeth Wilson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Esther P. O'Berry / Wife	4924 Baffin Bay Lane, Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Maryland Veteran's Cemetery	Dec 31, 2001	Crownsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ James E. Dooley	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	3years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the causa of death? 1[X] Yes 2[ ] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[X] Residance 8[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yas 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ George A. Sotos	D 43083	December 26, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

George A. Sotos, MD 9707 Medical Center Drive, #300, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	▶ G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15+1

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42873

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Walter Benton Owen	December 22 2001	12:50PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7912 Declaration Lane	Potomac	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
579-46-5520	1 [X] M 2 [ ] F	65 Yrs.			April 2,1936	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Potomac	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7912 Declaration Lane	20854	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 56-60	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Accountant	Accounting

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Owen III	Lillian F. Chandler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Magdalena Owen/ Spouse	7912 Declaration Lane, Potomac, MD 20854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	St Athanasius Cemetery	December 27 2001	Vienna, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Tracy A. Shiver	DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hodgkins Disease	6 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of deeth 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Daniel Rosenblum MD	D04766	December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel Rosenblum, M.D., 10400 Connecticut Avenue #606, Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ L. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

AMEND: #19b
mcg 12/18/01
AACO HEALTH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

For State Registrar

Reg. No. 2001 42874

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gwendolyn Theresa Owens

2. Date of Death Month Day Year: December 16, 2001

3. Time of Death: 11:08 PM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-20-5863

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 11, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 28 Farragut Road

10f. Zip Code: 21403

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Charles M. Reed

18. Mother's Name (First, Middle, Maiden Surname): Anna Gomoljak

19a. Informant's Name/Relationship (Type, Print): William W. Owens/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 Farragut Rd. Annapolis, MD ~~21401~~ 21403

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery

Date: 12-21-01

20c. Location - City or Town, State: Annapolis, Maryland

21. Signature of Funeral Service Licensee: Robert Wade

22. Name and Address of Facility: George P. Kalas Funeral Home 2972 Solomons Island Rd. Edgewater, MD 21037

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 6 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Emphysema

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sjoerd Beck, MD

29c. License number: D46052

29d. Date signed (Month, Day, Year): 12/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2001 Medical Parkway, Annapolis, MD Sjoerd Beck, M.D.

State Registrar

31. Date filed (Month, Day, Year): DEC 18 2001

32. Registrar's Signature: Geneva B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 20c.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-7135-027
cm
Derrick Markel Peterson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #10b. Per FH PGC 12-26-01 cr

Certificate of Death

Reg. No. 2001 42875

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Derrick Markell Peterson

2. Date of Death (Month, Day, Year): December 17, 2001

3. Time of Death: 9:27 P.M.

4a. Facility Name (If not institution, give street and number): 9635 Barrel House Road

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 577 15 2277

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 23 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 28, 1978

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard Co. ~~Prince George's~~

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9635 J. Barrel House Rd.

10f. Zip Code: 20723

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): Paul Peterson

18. Mother's Name (First, Middle, Maiden Surname): Rosie Robinson

19a. Informant's Name/Relationship (Type, Print): Paul Peterson - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9635 J. Barrel House Rd., Laurel, Maryland 20723

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park

Date: 12/21/2001

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: Juanita Braxton

22. Name and Address of Facility: Marshall's Funeral Home of MD
4308 Suitland Rd., Suitland, Maryland 20746

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GUNSHOT Wound to HEAD

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 12/17/01

28b. Time of Injury: P M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: SUBJECT SHOT

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): CAR

28f. Location (Street and Number or Rural Route Number, City or Town, State): 9635 Barrel House Road Laurel, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. Tins

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): December 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 5 2 5001

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42876

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Poore
2. Date of Death (Month, Day, Year): December 23, 2001
3. Time of Death: 8:50 PM
4e. Facility Name (If not institution, give street and number): Charles County Nursing Home
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579 36 7553
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 18, 1928
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8003 Veltri Drive
10f. Zip Code: 20744
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Yeer or Dates: 1950 1952
13. Was Decedent of Hispanic Origin? (Spacify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steamfitter
16b. Kind of Business/Industry: Private

17. Father's Neme (First, Middle, Last): Carl E. Poore, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Ada Liebrand

19a. Informent's Name/Relationship (Type, Print): Robert F. Poore, Jr. (SON)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5205 Caroline Circle, Waldorf, Maryland 20601

20a. Method of Disposition: XX 1☐ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Maryland Veterans Cemetery
Date: 1/2/2001
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Lars Frost
22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC ATRIAL FIBRILIATION. HYPERTENSION

23b. Dtd tobacco uss contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion ol cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D 44436
29d. Date signed (Month, Day, Year): DEC 24 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ASHVINKUMAR J PATEL MD 102 PAUL MELLON CT #102 WALDORF MD

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrer's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42877

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ella S. Proctor

2. Date of Death (Month, Day, Year): December 18, 2001

3. Time of Death: 2:05P M

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-40-8856

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 16, 1930

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Forestville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8005 Richard Dr.

10f. Zip Code: 20747

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Lynn Spears

18. Mother's Name (First, Middle, Maiden Surname): Indiana Hooks

19a. Informant's Name/Relationship (Type, Print): Cornelius I. Proctor/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8005 Richard Dr. Forestville, MD 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: Dec. 22, 2001

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Avery D. Mitchell

22. Name and Address of Facility: Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock -

Due to (or as a consequence of):

b. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

d. End Stage Renal Disease-dialysis dependent

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D50821

29d. Date signed (Month, Day, Year): 12/20/01

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): DR. MOFIKPARA A. WRIGHT, 1106 Spring St. #3, Silver Spring, MD. 20910

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: [illegible] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42878

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dennis Charles Patterson
2. Date of Death Month Day Year: December 20, 2001
3. Time of Death: 3:00 P.M.
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 139 32 8082
6. Sex: 1 M 2 F
7. Age *(In yrs. last birthday)*: 60 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 18, 1941
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 1854 Yeoman Court
10f. Zip Code: 21114
10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Superintendent of Operations
16b. Kind of Business/Industry: Steel Company

17. Father's Name *(First, Middle, Last)*: Charles Patterson
18. Mother's Name *(First, Middle, Maiden Surname)*: Annamae McCarthy

19a. Informant's Name/Relationship *(Type, Print)*: Mary Gennusa Patterson Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1854 Yeoman Court Crofton Maryland 21114

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Heart Church Cemetery
Date: Dec. 22, 2001
20c. Location - City or Town, State: Bowie Maryland

21. Signature of Funeral Service Licensee: Robert E. Evans
22. Name and Address of Facility: Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MELANOMA — TWO WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as e consequence of):

d. Due to (or as e consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other *(specify)* 9 Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No
26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M
29c. License number: D52245
29d. Date signed *(Month, Day, Year)*: DECEMBER 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL R. FREEDMAN MD 205 RIDGELY AVENUE ANNAPOLIS, MARYLAND 21401

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 26 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

15

DEC 2 6 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#5 PER F.H. G804 2-28-02 JAB

Certificate of Death

Reg. No. 2001 42879

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jesse Thomas Pitt, IV

2. Date of Death: Month December Day 22 Year 2001

3. Time of Death: 00:54 M

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-52-2580 (72)

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 21, 1953

9. Birthplace (State or Foreign Country): Wash., DC

Usual Residence of Decedent

10a. State: District of Columbia

10b. County

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2804 Rhode Island Ave., N.E.

10f. Zip Code: 20018

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Systems Technician

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Jesse T. Pitt, III

18. Mother's Name (First, Middle, Maiden Surname): Connie Fowler

19a. Informant's Name/Relationship (Type, Print): Janis M. Pitt - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2804 Rhode Island Ave., N.E. Wash., DC 20018

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lee's Crematory

Date: Dec. 27, 2001

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: John T Stewart, III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., DC 20019

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: 045203

29d. Date signed (Month, Day, Year): 12-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Smith, M.D. 7600 Carroll Ave., Takoma Park, MD 20912

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

DEC 5 2 5001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42880

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Priscilla Y. Page

2. Date of Death Month Day Year: Dec. 26, 2001

3. Time of Death: 5:40P M

4a. Facility Name (If not institution, give street and number): Magnolia Hall Nursing Center

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 215-36-0754

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4-10-1940

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Clinton, Maryland

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 7520 Surratis Rd.

10f. Zip Code: 20735

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BEAUTICIAN

16b. Kind of Business/Industry: COSMETOLOGY

17. Father's Name (First, Middle, Last): Norris Wilson

18. Mother's Name (First, Middle, Maiden Surname): Mary Stouts

19a. Informant's Name/Relationship (Type, Print): Mrs. Diane Bunting (Cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12617 Still Pond Creek Rd. Worton, Md. 21678

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): NCCOL U.M. Cem.

Date: 1/2/02

20c. Location - City or Town, State: Worton, Maryland

21. Signature of Funeral Service Licensee: ▶ Harry D. Feeze M000482

22. Name and Address of Facility: WALLEY FUNERAL SERVICE - CHESTERTOWN, MD 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. MULTI ORGAN FAILURE — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. TYPE 2 DIABETES MELLITUS — 20 YRS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jelc

29c. License number: 1-018824

29d. Date signed (Month, Day, Year): 12-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Seymour M.D. 122 Speer Rd. Chestertown, Maryland 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001

32. Registrar's Signature: ▶ G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42881

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elmer Joseph Pitcher, Jr.

2. Date of Death Month Day Year: Dec 26 2001

3. Time of Death: 1026P M

4a. Facility Name (If not institution, give street and number): 5955 Broomes Island Road

4b. City, Town, or Location of Death: Port Republic

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 220 26 4209

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 7 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Port Republic

10d. Inside City Limits: 1 Yes 2 X No

10e. Street and Number: 5955 Broomes Island Road

10f. Zip Code: 20676

10g. Citizen of What Country? United States

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): cable splicer

18b. Kind of Business/Industry: Telephone Co.

17. Father's Name (First, Middle, Last): Elmer Jospeh Pitcher, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Emma Isabelle Wagner

19a. Informant's Name/Relationship (Type, Print): Debra Horsmon- daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5820 Mackall Rd. St. Leonard MD 20685

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Waters Memorial Cemetery

Date: Dec 29 2001

20c. Location - City or Town, State: St. Leonard Maryland

21. Signature of Funeral Service Licensee: BRausch

22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBRO VASCULAR ACCIDENT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

28. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D-25435

29d. Date signed (Month, Day, Year): 12/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mukesh Mathur, M.D. Prince Frederick MD 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 02 2002

32. Registrar's Signature: Jennie B Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42882

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Robert	A.	Pinto Jr.	December 21, 2001	9:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12499 Loretta Road	Princess Anne	Somerset

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-28-3509	1 [X] M 2 [ ] F	72 Yrs.			04/27/1929	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Somerset	Princess Anne	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12499 Loretta Road	21853	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No 1955-1957	1 [ ] Yes 2 [X] No Specify:	Specify: USA

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Supervisor	Poultry Industry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert A. Pinto Sr.	Marguerite Windsor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Pinto/Wife	12499 Loretta Road, Princess Anne, MD 21853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Salisbury Crematory	12/22/2001	Salisbury, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James L Dearmon M00295	Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Prostate Cancer with Metastasis to Liver	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
D.O.	H57291 (MD)	12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
106 Milford Street, Suite 201, Salisbury, MD 21804 J.C. Patronia, D.O.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Donna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DEC 5 1 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42883

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MINNIE E. PARSONS
2. Date of Death (Month, Day, Year): December 24 2001
3. Time of Death: 0840 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-20-4295
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-11-23
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: SOMERSET
10c. City, Town or Location: Princess Anne
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 27902 Game Road
10f. Zip Code: 21853
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
18b. Kind of Business/Industry: Private Family

17. Father's Name (First, Middle, Last): Augustus JONES
18. Mother's Name (First, Middle, Maiden Surname): LESSIE GAME

19a. Informant's Name/Relationship (Type, Print): Mable JONES | Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27902 Game Road Princess Anne, MD 21853

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Cemetery
Date: 12-29-01
20c. Location - City or Town, State: MT. Vernon, MD

21. Signature of Funeral Service Licensee: Anthony E Waid
22. Name and Address of Facility: Anthony E. Waid Funeral Home 30699 Hampden Ave. Princess Anne MD 21853

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

E. Parsons

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ASCAD
Due to (or as a consequence of): b. HTN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Upper Respiratory Tract Infection

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD DME
29c. License number: D0054124
29d. Date signed (Month, Day, Year): 12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan Davis 3 Bistate Blvd Delmar MD 21875

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Geneva B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #20b, 12/24/2001, BMW, Montg. Co.

Certificate of Death

Reg. No. 2001 42884

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MITCHELL	T.	PRATHER	DEC.	18,	2001	3:25 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HEARTLAND HEALTH CARE CENTER	ADELPHI	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-20-1661	1☐ M 2☒ F	70 Yrs.					MAY 1, 1931	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	PRINCE GEORGES	LANHAM	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9903 POPLAR ST.	20706	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: KOREAN	1☐ Yes 2☒ No Specify:	Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	TEACHER	EDUCATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HERBERT THOMAS PRATHER SR.	ROSE ELEANOR BELL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ROSE ANN SWEETNEY/SISTER	5636 LINCOLN AVE., LANHAM, MD. 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MARYLAND NAT'L. CEM.	12-29-~~10~~ 2001	LAUREL, MD.

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
W. W. Chambers	M00091	CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

PERIPHERAL VASCULAR DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D42749	DEC. 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAYMOND NWADIUKO, M.D. 9831 GREENBELT RD. STE.101, LANHAM, MD. 20706

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	Geneva G. Lomax

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42885

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Roseanne Irene Penedo	December 24, 2001	3:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery Hospice - Casey House	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
045-38-8961	1☐M 2☒F	49 Yrs.			Feb 9, 1952	Connecticut

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Gaithersburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
225 Lazy Hollow Drive	20878	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Financial Analyst	Mortgage and Lending

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jose A. Penedo	Rosa Machado

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Americo A. Tadeu / Nephew	5504 McKinley Street, Bethesda, MD 20817

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	St. Peters Cemetery	Dec 26, 2001	Danbury, CT

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Rectal Carcinoma — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D 42452	December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Chitra Rajagopal, MD 18111 Prince Philip Drive, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42886

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Richard	M.	Philbin	December 18, 2001	0044 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Casey House	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
032-14-7965	1 [X] M 2 [ ] F	75 Yrs.			July 15, 1926	Massachusetts

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Rockville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13415 Oriental Court	20853	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1946-47	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Attorney	U.S. Government

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)	
Philip	Marris	Philbin	Ruth	Mower

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ann T. Philbin/wife	13415 Oriental Court, Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Chesapeake Crematory	12-19-01	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jennie A. Sparks	Rapp Funeral & Cremation Services 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cancer of Pancreas	2 mos
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ E.P. Libre MD	D09470	December 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E.P. Libre, M.D. 10400 Connecticut Ave., Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	▶ Jennie G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12+1

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No 2001 42887

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Katie	Bell	Pointer	Dec. 19, 2001	7:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mariner Health at Cir Manor	Kensington	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
419-40-2257	1☐ M 2☒ F	89 Yrs.			Nov. 7, 1912	New Jersey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
		Washington, DC	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1221 47th Place	20019	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Domestic	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bud Watkins	Purgie Watkins

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Wallace Pointer / Son	1221 47th PL, NE Washington, DC 20019

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lincoln Park	12/26/2001	Rockville, MD

21. Signature of Funeral Service Licensee: Benjamin R. Snowden

22. Name and Address of Facility: Snowden Funeral Home P.A. 246 N Washington St Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Myocardial infarction — Approximate Interval Between Onset and Death: Sudden

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:

b. Due to (or as e consequence of):

c. Due to (or as e consequence of):

d. Due to (or as e consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	23d. Dete of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

dementia

23e. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No	26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D53528	December 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daphna Henkin, MD
2309 Sherfield Rd. Suite 101, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	Penny G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42888

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Schuyler Post Jr.
2. Data of Death Month / Day / Year: DEC 19 2001
3. Time of Death: 1515
4a. Facility Name *(If not institution, give street and number)*: Ginger Cove
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 562-54-3428
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: August 6, 1908
9. Birthplace *(State or Foreign Country)*: California

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2101 River Crescent Drive
10f. Zip Code: 21401
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1925-1965
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Submariner
16b. Kind of Business/Industry: U.S. Navy
17. Father's Name *(First, Middle, Last)*: William Schuyler Post, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Estelle Johnson
19a. Informant's Name/Relationship *(Type, Print)*: William Schuyler Post III /son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16 Brush Hill Road Litchfield, CT 06759
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Naval Academy Cemetery — Date: 12/21/01
20c. Location - City or Town, State: Annapolis, MD
21. Signature of Funeral Service Licensee: Michael J. Doan
22. Name and Address of Facility: John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Heart failure — 3 D

Due to (or as a consequence of):
b. Hypertension — year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. DeAnn
29c. License number: D21438
29d. Date signed *(Month, Day, Year)*: Dec 19 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL J. CATENACCI 1201 MEDICAL PKWY STE 670 214 613 3059

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 2001
32. Registrar's Signature: Donna P Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42889

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jane Shook Park

2. Date of Death: Month December Day 13 Year 2001

3. Time of Death: 5:10 PM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 255-24-2423

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 26, 1923

9. Birthplace (State or Foreign Country): Illinois

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 525 Tayman Drive

10f. Zip Code: 21403

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Service

16b. Kind of Business/Industry: Army Signal Corps

17. Father's Name (First, Middle, Last): William Dean Shook

18. Mother's Neme (First, Middle, Meiden Surneme): Katharina Theis

19a. Informant's Name/Relationship (Type, Print): Ritchie Park/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 525 Tayman Drive Annapolis, MD 21403

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Memorial Gardens

Dete: 12/18/01

20c. Location - City or Town, Stete: Davidsonville, MD

21. Signature of Fatheral Service Licensee: Todd E. Lillard

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Adult Respiratory Distress — 48hrs

Due to (or es e consequence of):

b. Pneumonia — 48hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Breast Cancer — years

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case relerred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: DM35494

29d. Date signed (Month, Day, Year): 12/13/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Resnick Anne Arundel Medical Center

State Registrar

31. Date filed (Month, Day, Year): DEC 17 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 12 12/28/01 CMH AACO HEALTH DEPT.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42890

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): HOWARD M. Phelps
2. Date of Death: Month Dec, Day 9, Year 2001
3. Time of Death: 2055
4a. Facility Name (If not institution, give street and number): Anne Arundel Gen Hosp.
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: AA
5. Social Security Number: 216-28-6401
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 67 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 7 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: X Yes 2 ☐ No
10e. Street and Number: 23 Parole Street
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ~~X No~~ If Yes, Give Year or Dates: 1954-1974
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th; College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: Glen Burnie Printers
17. Father's Name (First, Middle, Last): William Phelps
18. Mother's Name (First, Middle, Maiden Surname): Floretta Bundy
19a. Informant's Name/Relationship (Type, Print): Adele P. Brown (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 Carrollton Ave Annapolis, Md. 21401
20a. Method of Disposition: 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 12/13/01
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: ▶Harry D. Reese M00482
22. Name and Address of Facility: Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Cardiac Insufficiency
Due to (or as a consequence of):
b. Arteriosclerotic Heart Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Diabetes Mellitus
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶William P. Jones MD Deputy
29c. License number: D06054
29d. Date signed (Month, Day, Year): 12/10/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year): DEC 13 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42891

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
KARELL NAHEEM PHILLIPS	12 / 5 / 2001	0350 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNIVERSITY OF MARYLAND MEDICAL SYSTEM	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1 [X] M 2 [ ] F	Yrs.	Ø / 15		11/20/01	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Glen Burnie	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6331 Harris Heights Ave.	21061	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, Whlte, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0	0	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Marcus Dunn	Ebony Phillips

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ebony Phillips(Mother)	6331 Harris Heights Ave Glen Burnie,Md21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Annapolis Memorial Gardens	12/10/01	Annapolis, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Harry D. Reese M004482	Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. PULMONARY HYPERTENSION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PREMATURITY, GASTROSCHISIS

23e. Did tobecco use contribute to the cause of deeth? 1 [ ] Yes 2 [X] No 3 [ ] Probebly 4 [ ] Unknown

24e. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy tindings available prior to completion of ceuse ot death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Sandip Patel	D55511	12/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDIP PATEL 22 SOUTH GREENE STREET, ROOM NSW 68 BALTIMORE, MARYLAND 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 12 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42892

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Magdalene	Fanny	Richardson	December 28, 2001	1:00 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
736 Principio Road	Port Deposit	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-20-8505	1☐M 2☒F	76 Yrs.			Sept. 11, 1925	North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Port Deposit	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
736 Principio Road	21904	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Seven Years		Homemaker	Personal Residence

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James J. Eller	Nancy Blevins

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Luther J. Richardson (husband)	736 Principio Road, Port Deposit, Maryland 21904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Asbury Cemetery	01/02/02	Port Deposit, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas M. Patterson, Sr.	Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

rjw

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BRONCHOGENIC CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MENINGIOMA - CEREBELLO PONTINE ANGLE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD RAKESH K MATHUR	D 39170	12-28-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh K. Mathur, M.D., 1716 Harford Road, Suite 105, Fallston, Maryland 21047

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 31 2001	▶

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42893

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): QUILLARENE RICE
2. Date of Death Month 12 Day 17 Year 2001
3. Time of Death 1138 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-80-8695
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 45 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 5, 1956
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11738 S. Laurel Dr. #2C
10f. Zip Code: 20708
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Employees Relation Specialist
18b. Kind of Business/Industry: Dept of Agriculture

17. Father's Name (First, Middle, Last): Joseph Baker
18. Mother's Name (First, Middle, Maiden Surname): Rosa Mae Langston

19a. Informant's Name/Relationship (Type, Print): Rosa B. Freeman/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4914 4th St. NW Washington, D.C. 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
Date: 12-22-2001
20c. Location - City or Town, State: Brentwood, Md.

21. Signature of Funeral Service Licensee: J. P. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St.N.W. Washington, D.C. 20011

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. cor pulmonale — Approximate Interval Between Onset and Death: 3 yrs.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. restrictive lung disease — 5 yrs
Due to (or as a consequence of):
c. pulmonary hypertension — 5 yrs
Due to (or as a consequence of):
d. ventricular septal defect — 40 yrs

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Michael A Lincoln
29c. License number: 024293
29d. Date signed (Month, Day, Year): 12/17/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael A. Lincoln, M.D. 10313 Georgia Avenue Silver Spring MD 20902

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: Bernice B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

(12)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42894

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LARRY Roberson	December 17, 2001	12:16 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs if last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
244-74-8277	1 ☐ M 2 ☐ F	57 Yrs.			Sept 30, 1944	Washington DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Charles	Waldorf	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10905 Maryland Woods Court	20602	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	6+	Logistics Officer	U.S. Air Force

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Tobe Roberson	Patience Moore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mildred Roberson - Spouse	10905 Maryland Woods Ct., Waldorf, MD 20602

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Maryland Veterans Cem.	12/21/2001	Cheltenham, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Suawara L Brayton	Marshall's Funeral Home of Maryland 4308 Suitland Road, Suitland MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy — Approximate Interval Between Onset and Death: 4 YEARS

Due to (or as a consequence of):

b. heart failure — 4 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 ☒ Yes 2 ☐ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	4147357 PT95	December 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pierre Theodore, M.D. 600 North Wolfe St. Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(12)

DHMH 17 Rev 1/2001

ORIGINAL

DEC 3 8 5001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42895

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bessie Rankin
2. Date of Death Month Day Year: December 19, 2001
3. Time of Death: 12:05AM
4a. Facility Name *(If not institution, give street and number)*: Andrus House
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 238-10-4079
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 16, 1913
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Falls Church
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7966 Yancey Drive
10f. Zip Code: 22042
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Officer
16b. Kind of Business/Industry: U.S. Navy

17. Father's Name *(First, Middle, Last)*: Louis Dewitt King
18. Mother's Name *(First, Middle, Maiden Surname)*: Mayvalonia Black

19a. Informant's Name/Relationship *(Type, Print)*: Kristin F. Falcon/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7966 Yancey Dr. Falls Church, VA 22042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cemetery
Date: 12/26/01
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: [signature] LFSP
22. Name and Address of Facility: Robert J. Murphy Funeral Home 4510 Wilson Blvd., Arlington, VA 22203

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Respiratory failure

Due to (or as a consequence of):
b. Pulmonary Fibrosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia, Congestive heart failure
Hypertension, Pneumonia
Cerebrovascular Accidents

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 39501
29d. Date signed *(Month, Day, Year)*: 12-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hugh Holder M.D. 101 Stone Gate Drive, SilverSpring Md. 20905

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 24 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 29e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42896

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Alice Russum

2. Data of Death Month Dey Yaar: December 23, 2001

3. Time of Death: 2:00 PM

4a. Facility Name *(If not institution, give street and number)*: Center Chestertown Nursing & Rehabilitation

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 213-22-4798

6. Sex: 1☐M 2☒F

7. Aga *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yaar)*: April 25, 1926

9. Birthplace *(Stata or Foraign Country)*: Pomona, MD

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Insida City Limits: 1☒Yes 2☐No

10e. Street and Number: 415 Morgnec Road

10f. Zip Code: 21620

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yaer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yes 2☒No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: Caucasion

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Line Worker/Laborer

16b. Kind of Business/Industry: Food Manufacturer

17. Father's Name *(First, Middle, Last)*: Lloyd S. Mulford

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Reba Chaires

19a. Informant's Name/Raletionship *(Type, Print)*: Ralph B. Russum/Husband

19b. Mailing Address *(Street and Numbar or Rurel Route Number, City or Town, Stata, Zip Code)*: 402 Morgnec Road, Apt. 2B, Chestertown, MD

20a. Mathod of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Placa of Disposition *(Nama of cematary, crematory or other piece)*: Chester Cemetery / Data: December 28, 2001

20c. Location - City or Town, State: Chestertown, MD

21. Signatura of Funarel Service Licensee: J Willis Wells

22. Name and Addrass of Facility: J. Willis Wells Funeral Service 211 Heron Point, Chestertown, Maryland

Physician /Medical Examiner

23a. Part. Enter the disaasa, or complicetions that caused the death. Do not antar tha moda of dying, such es cardiac or respiratory arrast, shock, or heart failure. List *only ona* causa *on aach* lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disease or condition resulting in death):
a. Arterio Sclerotic Cardio Vascular Disease — > 5 years

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b. Dua to (or as a consequenca of):

c. Dua to (or as e consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☒No 9☐Unknown

23c. If yas, outcome of pregnancy 1☐Liva birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant condftions** contributing to daath but not rasulting in tha undarlying ceuse given in Part i.

COPD/Restrictive Lung Disease/HTN/Afib/HxCHF Seizure D/O/HxTHA/HxRecurrent DVT/Depression Hx ARDS

23a. Did tobacco usa contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings availabla prior to completion of causa of daath? 1☐Yas 2☐No

25. Was case refarred to medical axaminer? 1☐Yas 2☒No

26. Placa of Daath *(Chack only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Othar: 4☒Nursing Homa 5☐Rasidance 6☐Othar *(Specify)*

27. Manner of Deeth: 1☒Naturel 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Numbar or Rural Routa Numbar, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifier *(Check only one)*: 1☒**Certifying Physician:** To tha best of my knowledga, death occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end mannar stated.

29b. Signature and title of certifier: Neil Stoddard MD

29c. License numbar: D50996

29d. Data signad *(Month, Dey, Year)*: 12/26/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Neil Stoddard MD 100 Brown St Chestertown, MD 21620

5

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 26 2001

32. Registrar's Signatura: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42897

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rockwell Ringgold
2. Date of Death Month / Day / Year: December 21, 2001
3. Time of Death: 6:15a.m.
4a. Facility Name *(If not institution, give street and number)*: 110 S. Linden Street
4b. City, Town, or Location of Death: Sudlersville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 218-24-4803
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 27, 1930
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 421 Pine Tree Road
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Operator
16b. Kind of Business/Industry: Stone

17. Father's Name *(First, Middle, Last)*: Edward Ringgold
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Hines

19a. Informant's Name/Relationship *(Type, Print)*: Melva Winchester/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 168 Misty Way, Hartley, Delaware 19953

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Boardly Chapel Cemetery
Date: 12/27/2001
20c. Location - City or Town, State: Pondtown, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Squamous cell carcinoma, lung — 4 months
Due to (or as a consequence of):
b. COPD — 5 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus Type II, ↑Cholesterol

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Grandson's House

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D57735
29d. Date signed *(Month, Day, Year)*: 12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Frederick Delboy, 6602 Church Hill Road, Chestertown, MD 21620

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42898

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maria Sue Reeder

2. Date of Death (Month, Day, Year): December 19, 2001

3. Time of Death: 9:30 PM

4a. Facility Name (If not institution, give street and number): Manor Care- Wheaton

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-09-5861

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 7, 1908

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3312 Chiswick Ct #2C

10f. Zip Code: 20906

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Credit Supervisor

16b. Kind of Business/Industry: Credit Bureau

17. Father's Name (First, Middle, Last): James B. Reish

18. Mother's Name (First, Middle, Maiden Surname): Joey M. Keller

19a. Informant's Name/Relationship (Type, Print): Geraldine J. Walsh / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12061 Claridge Road, Wheaton, MD 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: Dec 22, 2001

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: ▶ Willi T Bl

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 3 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Uterine Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D 53528

29d. Date signed (Month, Day, Year): December 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daphna Henkin, MD 2309 Shorefield Road, Wheaton, MD 20902

State Registrar

31. Date filed (Month, Day, Year): DEC 24 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42899

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET H. RUMSEY
2. Date of Death Month Day Year: DECEMBER 24,2001
3. Time of Death: 2:40 PM
4a. Facility Name *(If not institution, give street and number)*: SHARON NURSING HOME
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-32-5228
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 9, 1913
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Sandy Spring
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 18201 Slade School Road
10f. Zip Code: 20860
10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Nurse
16b. Kind of Businass/Industry: Dept. of Health

17. Fathar's Nama *(First, Middle, Last)*: George Hogett
18. Mothar's Name *(First, Middle, Maiden Surnama)*: Bertha Hollenbough

19a. Informant's Name/Ratationship *(Type, Print)*: Albert B. Carrozza / Attorney
19b. Mailing Address *(Streat and Number or Rural Routa Number, City or Town, State, Zip Coda)*: P. O. Box 455, Olney, Maryland 20830

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cematary, cramatory or other place)*: Gate of Heaven Cemetery | Data: 12/27/01
20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensaa: Muriel H. Barber
22. Nama and Addrass of Facility: Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that ceused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona ceusa on aach lina.

Approximate Intarval Batween Onsat and Death

Immediate Ceuse (Finel disaase or condition rasulting in daath)
a. Sepsis — 2 Days

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaasa or injury that initiated events rasulting in daath) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Endstage Dementia

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findinga available prior to compiation of ceusa of deeth? 1☐ Yaa 2☐ No

25. Was cesa rafarred to medical examiner? 1☐ Yas 2☒ No
26. Place of Death *(Check only ona)*: Hospitel: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA | Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straet, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledge, daath occurred at tha time, date and place, and dua to tha causa(s) and mannar es stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: MD
29c. Licensa number: D 43202
29d. Data signed *(Month, Day, Year)*: DECEMBER 26,2001

30. Nama and addraas of person who completed causa of death (Item 23a) (Type, Print): Charlene Ozanne-Blankfard, M.D. 3305 N. Leisure World Blvd.,Silver Spring,Md.20906

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42900

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Amy Pettebone Russell

2. Date of Death: Month 12 Day 10 Year 2001

3. Time of Death: 1045 Am

4a. Facility Name (If not institution, give street and number): Ginger Cove Health & Rehab Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-05-6390

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 6, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2304 River Crescent Drive

10f. Zip Code: 21401

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Baltimore Gas & Electric

17. Father's Name (First, Middle, Last): John E. Pettebone

18. Mother's Neme (First, Middle, Maiden Sumame): Ida Russell

19a. Informant's Name/Relationship (Type, Print): Virginia R. Bell (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1491 Granview Rd. Arnold, Maryland 21012

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Baltimore Crematory

Date: 12/13/2001

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Bernard C. Taylor

22. Name and Address of Fecility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Maryland 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in death)

a. Alzheimer Dementia — 4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John D. Fuller MD

29c. License number: D30718

29d. Date signed (Month, Day, Year): 12-10-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Fuller MD, 2003 Med. Pkwy #100, Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 11 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 42901

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Eugene F. Spencer	December 27, 2001	8:33 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harford Memorial Hospital	Havre de Grace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
182-03-1055	1☒M 2☐F	84 Yrs.			Oct. 31, 1917	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Rising Sun	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
135 South Queen Street	21911	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Assembly Line Worker	Auto Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Spencer	Rose Haskin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Evelyn F. Spencer/Wife	135 South Queen Street, Rising Sun, MD 21911

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hopewell Cemetery	12-31-2001	Port Deposit, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Richard L. Goodie	R. T. Foard Funeral Home, P. A. 111 S. Queen Street, Rising Sun, MD 21911

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Adult Respiratory Distress Syndrome.	1 WK.
	Due to (or as a consequence of): Pneumonia.	1 WK.
	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypoxemic Encephalopathy

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	26a. Date of Injury (Month, Day Year)	26b. Time of Injury	26c. Injury at Work?	26d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Woman MD	D 32609	12/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kammidon Murtaugh DO 1106 Revolution St. Havre De Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 31 2001	B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12/27/01 2033 Spencer, Eugene Francis 20+1VA

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 42902

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RONALD SULLIVAN
2. Date of Death (Month, Day, Year): DECEMBER 20, 2001
3. Time of Death: 4:40 AM
4a. Facility Name (If not institution, give street and number): 363 WEST MAIN STREET
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 172-42-4058
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): DECEMBER 21, 1952
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CECIL
10c. City, Town or Location: ELKTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 363 WEST MAIN STREET
10f. Zip Code: 21921
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
18b. Kind of Business/Industry: TRUCKING

17. Father's Name (First, Middle, Last): JOHN L. SULLIVAN
18. Mother's Name (First, Middle, Maiden Surname): LOUISE GUIDO

19a. Informant's Name/Relationship (Type, Print): WIFE IRENE SAVAGE SULLIVAN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 363 WEST MAIN ST. ELKTON, MD 21921

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. PETER & PAUL CEMETERY | Date: 12/28/01
20c. Location - City or Town, State: SPRINGFIELD, PA
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: GEE FUNERAL HOME 259 E. MAIN ST. ELKTON, MD 21921

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Advanced Pancreatic Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [/] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [/] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [/] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [/] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [/] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D35653
29d. Date signed (Month, Day, Year): 12-27-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha Hosford-Skaps, M.D., 111 W. High St #104, Elkton MD 21921

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42903

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELEANORE SHARP

2. Date of Death Month / Day / Year: DEC 23rd 2001

3. Time of Death: 609 AM

4a. Facility Name *(If not institution, give street and number)*: Larkin Chase nursing Center

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-20-8096

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 19, 1924

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6492 Landover Rd

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Long Distance Telephone Operator

16b. Kind of Business/Industry: C&P Telephone

17. Father's Name *(First, Middle, Last)*: George W. Moran

18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie Adela Sweeney

19a. Informant's Name/Relationship *(Type, Print)*: Deborah A. Stinnett - Friend

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2435 Hallowing Point Rd., Prince Frederick, Md 20678

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery

Date: 01/02/01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Arlen Smith

22. Name and Address of Facility: Gasch's Funeral Home P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Treated pneumonia

Parkinson's Syndrome

Degenerative arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N Negussie MD

29c. License number: D45471

29d. Date signed *(Month, Day, Year)*: Dec 23rd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YEHEYIS NEGUSSIE, M.D 4404 Queensbury Rd Riverdale, MD 20737

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 28 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42904

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles William Spaar, Sr.

2. Date of Death (Month, Day, Year): December 24, 2001

3. Time of Death: 2:19 p.m.

4a. Facility Name (If not institution, give street and number): 9000 Briar Croft Lane # 312

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 236-34-6068

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 23, 1928

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9000 Briarcroft Lane Apt# 312

10f. Zip Code: 20708

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secret Service

16b. Kind of Business/Industry: Treasury Department

17. Father's Name (First, Middle, Last): Howard Lewis Spaar

18. Mother's Name (First, Middle, Maiden Surname): Ella Cecelia Hilton

19a. Informant's Name/Relationship (Type, Print): Charles William Spaar, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 43 Chrisba Road Severna Park, Maryland 21146

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 12/31/01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Allen Smith

22. Name and Address of Facility: Gasch's Funeral Home P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Coronary Artery Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Abdominal Aortic Aneurysm, Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John D. Q

29c. License number: D24035

29d. Date signed (Month, Day, Year): December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E.S Machado 321 Prince George Street, Laurel Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(25) IVa

DEC 0 6 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42905

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Walker Sutherland
2. Date of Death (Month, Day, Year): December 23, 2001
3. Time of Death: 1:51AM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-03-9920
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 1, 1916
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8900 Marquis Lane
10f. Zip Code: 20735
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [XX] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [XX] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Fed. Govt. (Navy Dept)

17. Father's Name (First, Middle, Last): James Buckner Sutherland
18. Mother's Name (First, Middle, Maiden Surname): Irene Agnes

19a. Informant's Name/Relationship (Type, Print): John W. Sutherland (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5914 Firewood Trail Greensboro, N.C. 27410

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery
Date: Dec. 28 2001
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Lou Grant
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MASSIVE ISCHEMIC STROKES ON CEREBELLUM AND OCCIPITAL LOBE — DAYS.
Due to (or as a consequence of):
b. CEREBRAL ATHEROSCLEROSIS — YEARS.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. HYPERTENSIVE CARDIOVASCULAR DISEASE — YEARS.
Due to (or as a consequence of):
d. DIABETES MELLITUS. TYPE II — Years.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
history of colitis and dehydration and bronchitis.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [XX] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D0012884
29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter W. Yim, M.D. 7900 Old Branch Ave. Suite 101 Clinton, Maryland 20735

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Barbara B. Goode

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

15 11a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 8 PER
1- For State Registrar FH G804 02/26/02 RR

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42906

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Josephine M. Sgro	December 19, 2001	1:05a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6100 Westchester Park Drive #1113	College Park	Prince Georges

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213 - 40 - 6310	1☐M 2☒F	60 Yrs.			~~January 4, 1941~~ 02/04/41	Washington D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	College Park	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6100 Westchester Park Drive #1113	20740	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Executive Secretary	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Salvadore Sgro	Lena V. Teresi

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Brenda Brooks/Personal Representative	14017 Heatherstone Dr. Bowie, MD 20720

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Fort Lincoln Crematory	12-22-01	Brentwood, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Fort Lincoln Funeral Home Inc. 3401 Bladensburg Road, Brentwood, Maryland 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Breast Cancer	many years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arthritis

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] Covering Physician	D31001	12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stuart J. Turkewitz, M.D. 7500 Greenway Center Drive suite430 Greenbelt, Maryland 20770

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 42907

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Gizella	Spock	December 24, 2001	12:35 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Bradford Oaks Nursing Home	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
168-14-5078	1 M 2 X F	91 Yrs.			04/01/1910	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Camp Springs	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6808 Berkshire Drive	20748	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Seamstress	Tailoring

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Stephen Kuskolis	Esther Varga

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward Vitagliano/Son-in-Law	6808 Berkshire Drive Camp Springs, Maryland 20748

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify)	Calvary Cemetery	12/27/2001	Drums, Pennsylvania

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George P. Kalas	George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 Yes 2 X No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnency 4 Pregnent at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 X Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D19481

29d. Date signed (Month, Day, Year) 12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frank Ryan MD 1179 Chillum Rd #203 Hyattsville MD 20782

State Registrar

31. Date filed (Month, Day, Year) DEC 27 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

DEC 5 5 5001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42908

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clyde Henry Saul
2. Date of Death (Month, Day, Year): December 27, 2001
3. Time of Death: 1:42 AM
4a. Facility Name (If not institution, give street and number): Larkin Chase Nursing Center
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-16-4740
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03/26/1916
9. Birthplace (State or Foreign Country): Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hillcrest Heights
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4004 21st Avenue
10f. Zip Code: 20748
10g. Citizan of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mortgage Banker
16b. Kind of Business/Industry: Banking
17. Father's Name (First, Middle, Last): Henry W. Saul
18. Mother's Name (First, Middle, Maiden Surname): Nettie Boward
19a. Informant's Name/Relationship (Type, Print): Arlene R. Rosch / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12702 Milan Way Bowie, Maryland 20715
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wash. Nat'l. Cemetery
Date: 12/31/2001
20c. Location - City or Town, State: Suitland, Maryland
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	a. DIFFUSE METASTATIC BONE CARCINOMA	< 1 month
Due to (or as a consequence of):	b. esophageal CARCINOMA	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of):	c. Hypertension	10 years
	d. Covonary artery disease	> 10 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Alain G. Champaloux MD
29c. License number: D42049
29d. Date signed (Month, Day, Year): december 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alain G. CHAMPALOUX MD Upper Marlboro MD. 20772

State Registrar

31. Data filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: [signature] B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

DEC 5 1 500.

01-6986-033
Herbert A. Spears
BS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#5 per fh G804 022702 ss

Certificate of Death

Reg. No. 2001 42909

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert A. Spears

2. Date of Death (Month, Day, Year): December 11, 2001

3. Time of Death: 23:16 PM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: ~~578-68-3968~~ ~~578-68-3962~~

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 09, 1949

9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGES

10c. City, Town or Location: TEMPLE HILLS

10d. Inside City Limits: ☒ 1 Yes 2 ☐ No

10e. Street and Number: 7107 EISENHOWER CT.

10f. Zip Code: 20748

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TELEPHONE TECHNICIAN

16b. Kind of Business/Industry: VERIZON

17. Father's Name (First, Middle, Last): HERBERT SPEARS

18. Mother's Name (First, Middle, Maiden Surname): ODELSER WILLIAMS

19a. Informant's Name/Relationship (Type, Print): LANITA SPEARS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3700 9TH ST. SE #520 WASHINGTON, DC 20032

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WASHIGNTON NATIONAL CEM.

Date: 12-19-01

20c. Location - City or Town, State: SUITLAND, MARYLAND

21. Signature of Funeral Service Licensee: L. P. Marshall

22. Name and Address of Facility: MARHSALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GUNSHOT WOUND OF HEAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 12/8/01 FOUND

28b. Time of Injury: 1722 FOUND M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: SUBJECT WAS SHOT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): OUTSIDE RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 7107 EISENHOWER COURT, TEMPLE HILLS, MD

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): December 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY GRIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Sandra B. Sparks

(10)

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

DEC 2 6 2001

Hayes Suber
Unknown 01-326
CJ
01-6711-033

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42910

AMEND ITEM #20a,b,c per ME G803 012202 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month	Dey	Yeer	3. Time of Death
Hayes	Suber	November	25	2001	05:26 P.M.

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Deys	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247-34-9279	1☒M 2☐F	90 Yrs.					March 25, 1911	Washington, DC

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
District of Columbia		Washington	1☒Yes 2☐No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
4507 - B Street, SE #102	20019	United States

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - Americen Indien, Bleck, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
8 years		Cook	Private

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Landa Suber	Minnie Rollins

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bessie Borden - Caretaker	4507 - B St., SE Washington, DC 20019

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State
1☒Burial 2☒Cremation 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)	Lee's Crematory ~~Quantico National Cemetery~~	Jan. 16, 2002 ~~12/20/2001~~	Clinton, MD ~~Triangle, VA~~

21. Signature of Funeral Service Licensee	22. Name and Address of Feciility
John J. Stewart III	Stewart Funeral Home, Inc. 4001 Benning Rd., NE Washington, DC 20019

Physician /Medical Examiner

23a. Pertl. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediate Cause (Final diseese or condition resulting in deeth)	e. MULTIPLE INJURIES	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest	b. Due to (or es e consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uee contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy findings available prior to completion of ceuse of deeth?
1☒Yes 2☐No	1☒Yes 2☐No

25. Wes case referred to medicel exeminer?	26. Piece of Deeth (Check only one)	
1☒Yes 2☐No	Hospitel: 1☐Inpetient 2☒ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28e. Dete of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined	11/25/01	4:44 P.M	1☐Yes 2☒No	Subject pedestrian struck by vehicle

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Roadway	41st and Benning Road N.E. Washington, D.C.

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner es steted.
2☒ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King M.D.	O.C.M.E.	November 26, 2001

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)
Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 13 2001	

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 13 2001

RKD

01-7308-510

WILLIAM SMITH UNPENDED 013102: ITEMS #23a,b,c,27,28a-f per ME (8805) SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42911

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Smith
2. Date of Death (Month, Day, Year): DECEMBER 25, 2001
3. Time of Death: 9:50A.M.
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND SHOCK TRAUMA CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-05-6696
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-11-1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 309 Roosevelt Dr.
10f. Zip Code: 21620
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Private Family
16b. Kind of Business/Industry: Chauffeur

17. Father's Name (First, Middle, Last): Jacob Smith
18. Mother's Name (First, Middle, Maiden Surname): Louise Thompson

19a. Informant's Name/Relationship (Type, Print): Keith Lamon Smith(Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18451 Dome Hollow DR.Germantown,Md.20874

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Janes U.M.Cemetery
Date: 1-5-02
20c. Location - City or Town, State: Chestertown,Md.

21. Signature of Funeral Service Licensee: Harry A. Reese M00482
22. Name and Address of Facility: WALLEY FUNERAL SERVICE Chestertown,md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. BRONCHOPNEUMONIA COMPLICATED BY HEMORRHAGE OF PERITRACHEAL ABSCESS DUE TO TRACHEOSTOMY PLACEMENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CENTRAL CORD SYNDROME

Due to (or as a consequence of):
c. CERVICO-THORACIC SPINE SUBLAXATION

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide ~~5 [X] Pending investigation~~ 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 11-22-01
28b. Time of Injury: Unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject fell, hyperextending neck
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 549 High St., Chestertown, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Carlton Locke, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 26, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 03 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42912

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Keith Paul Smith
2. Date of Death (Month, Day, Year): December 11, 2001
3. Time of Death: 10:40 PM
4a. Facility Name (If not institution, give street and number): Kent & Queen Anne Hospital
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 525-33-2935
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 35 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): July 7, 1966
9. Birthplace (State or Foreign Country): Washington,D.C.

Usual Residence of Decedent

10a. State: Md
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 22939 Bayshore Road
10f. Zip Code: 21620
10g. Citizen of What Country? USA

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Host
16b. Kind of Business/Industry: Watermans Crab House

17. Father's Name (First, Middle, Last): Francis Dale Smith
18. Mother's Name (First, Middle, Maiden Surname): Nancy Joan Gascon

19a. Informant's Name/Relationship (Type, Print): Nancy J. Gascon (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22939 Bayshore Road Chestertown, Md. 21620

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wesley Chapel Cem.
Date: 12/15/2001
20c. Location - City or Town, State: RockHall, Maryland

21. Signature of Funeral Service Licensee: Kurt J. Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home,P.A. 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only ona causa on aach fine. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOPULMONARY ARREST
Due to (or as a consequence of):
b. Respiratory ARREST
Due to (or as a consequence of):
c. RECURRENT EXACERBATION OF ASTHMA
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal daath 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.
Hypertension, HypoThyroidism, OBESITY, CHRONIC OBSTructive Pulmonary Disease CORONARY ARTERY Disease

23e. Did tobecco usa contribute to the cause of daath? 1 Yes 2 X No 3 Probebly 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and menner as stated. 2 **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.
29b. Signature and title of certifier: J. C. Arrabal Jr M.D
29c. License number: D23889
29d. Date signed (Month, Dey, Yaar): 12/13/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. ARRABAL JR. MD, 223 High Street, Chestertown Md. 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 14 2001
32. Registrar's Signature: Donna B. Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42913

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Marr Scott
2. Date of Death (Month, Day, Year): Dec 6 2001
3. Time of Death: 4:42 AM
4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 523-07-6917
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 3, 1922
9. Birthplace (State or Foreign Country): Colorado

Usual Residence of Decedent

10a. State: Md
10b. County: Quenn Anne's
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 120 River Road
10f. Zip Code: 21620
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Datas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive
16b. Kind of Business/Industry: Chrysler

17. Father's Name (First, Middle, Last): Crawford Madden Scott
18. Mothar's Name (First, Middle, Maiden Surnama): Gertrude Olson

19a. Informant's Name/Relationship (Type, Print): Dorris M. Scott (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 River Road Chestertown, Md. 21620

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Cntr. — Date: 12/11/01
20c. Location - City or Town, State: Stevensville, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory distress syndrome — weeks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease
Hyperlipidemia
Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residance 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] MD
29c. License number: D25750
29d. Date signed (Month, Day, Year): 12/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT SANCHEZ, MD 508 IDLEWILD AVENUE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): DEC 11 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

John Scott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42914

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Carrie	M.	Steele	December 25, 2001	10:17 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-22-2411	1☐M 2☒F	81 Yrs.			10/12/1920	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Somerset	Princess Anne	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
31309 West Post Office Road	21853	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	None	Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Aleph Wood	Beulah Wood

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hershel Steele/Husband	31309 West Post Office Road, Princess Anne, MD 21853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Comfort Cemetery	12/28/2001	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ James F. Hinman M00295	Hinman Funeral Home 11673 Somerset Ave., Princess Anne, Md. 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): N/A	5 years
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ USHA NATESAN	D051359	12/26/01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
106 Pine Bluff Road Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Penina G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CARRIE STEELE #578-22-2411 12/25/01 2217 814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42915

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY E. STERLING
2. Data of Death Month Day Year: December 23, 2001
3. Time of Daath: 9:35 A M
4a. Facility Name (If not institution, give street and number): McCready Memorial Hospital
4b. City, Town, or Location of Daath: Crisfield
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 220-16-9204
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 94 Yrs.
If Undar 1 Year: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): January 26, 1907
9. Birthplace (Stata or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Somerset
10c. City, Town or Location: Crisfield
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 3310 Lawsonia Road
10f. Zip Coda: 21817
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired): Homemaker
16b. Kind of Business/Industry: At Home

17. Father's Name (First, Middle, Last): Merley Riggin
18. Mother's Name (First, Middla, Maidan Surname): Reba Sears

19a. Informant's Name/Ralationship (Type, Print): Marilyn Sterling (Daughter)
19b. Meiling Addrass (Street end Numbar or Rural Route Number, City or Town, Stata, Zip Code): 3310 Lawsonia Road - P. O. Box 162 - Crisfield, MD 21817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Nama of cematary, cramatory or othar placa): Asbury Cemetery
Data: 12/27/01
20c. Location - City or Town, Stete: Crisfield, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.
22. Nama and Address of Facility: Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield,MD 21817

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not anter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each line.
Approximete Interval Between Onsat and Daath: months

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC COLON CANCER
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last
b. Due to (or as a consequance of):
c. Dua to (or as a consequenca of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yas 2☒ No 9☐ Unknown
23c. If yes, outcoma of pregnancy 1☐ Live birth 2☐ Fetal daath 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Othar (specify) 9☐ Unknown
23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23e. Did tobacco use contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings availabla prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Daath (Chack only ona)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Residance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Straat and Numbar or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To tha best of my knowledga, death occurrad at the time, date and placa, and due to the cause(s) and manner as steted. 2☐ Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to tha causa(s) and mannar stated.
29b. Signature and title of certifier
29c. Licensa number: D 39813
29d. Data signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): M. Atkins, M.D. - 803 W. Main Street - Crisfield, MD 21817

State Registrar

31. Data filed (Month, Day, Yaar): DEC 2 7 2001
32. Registrar's Signatura: Geneva G. Coates

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DEC 5 7 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #8,12/31/2001,BMW,Montg.Co. *Certificate of Death* Reg. No. 2001 42916

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fern Rice Solomon
2. Date of Death (Month, Day, Year): December 26, 2001
3. Time of Death: 9:02AM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 370-16-7822
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. ~~11~~ 15, 1921
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8502 West Howell Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Librarian
16b. Kind of Business/Industry: Montgomery County

17. Father's Name (First, Middle, Last): Garfield T. Rice
18. Mother's Name (First, Middle, Maiden Surname): Carrie Hannon

19a. Informant's Name/Relationship (Type, Print): Robert Solomon/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8502 West Howell Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: Dec 29 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: David E. Perry, M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Embolism — Minutes
Due to (or as a consequence of):
b. Cardiovascular Disease — Years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
c. Atrial Fibrillation — Years
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul D O'Brien MD
29c. License number: D31027
29d. Date signed (Month, Day, Year): DEC 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL D. O'BRIEN MD SUBURBAN HOSPITAL 8600 OLD GEORGETOWN RD BETHESDA 20814

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Solomon, Fern R 12-26-01 902 Am

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42917

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): June Beatrice Swangstu
2. Date of Death (Month, Day, Year): December 24, 2001
3. Time of Death: 5:20 AM
4a. Facility Name (If not institution, give street and number): Hillhaven Nursing Center
4b. City, Town, or Location of Death: Adelphi
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 392-18-5069
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 28, 1920
9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9716 Hedin Drive
10f. Zip Code: 20903
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tavern Operator
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Andrew Swangstu
18. Mother's Name (First, Middle, Maiden Surname): Caterina Levis

19a. Informant's Name/Relationship (Type, Print): Gloria S. Orton / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9716 Hedin Drive, Silver Spring, MD 20903

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Dec 24, 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: John C. Barber
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Charles M. Benner, MD
29c. License number: D 31563
29d. Date signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles M. Benner, MD 11251 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42918

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Stevenson Scrivener
2. Date of Death Month Day Year: December 24, 2001
3. Time of Death: 8:30PM
4a. Facility Name *(If not institution, give street and number)*: 3807 East-West Highway
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-28-2164
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 22, 1913
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3807 East-West Highway
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney
16b. Kind of Business/Industry: Private Practice

17. Father's Name *(First, Middle, Last)*: Samuel Scrivener
18. Mother's Name *(First, Middle, Maiden Surname)*: Vida Elizabeth Stevenson

19a. Informant's Name/Relationship *(Type, Print)*: Thomas W. Lippy/Son-in-law
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7439 Foxleigh Way, Alexandria, Virginia 22315

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rock Creek Cemetery — Date: Dec 28 2001
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service License: David E. Perry. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myelogenous Leukemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward T. Cullen MD
29c. License number: D0026607
29d. Date signed *(Month, Day, Year)*: December 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward T. Cullen, M.D. 4333 Old Branch Avenue, Marlow Heights, Maryland 20748

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signature: Lenora G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

30+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42919

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM AUSTIN SHAW

2. Date of Death (Month, Day, Year): DECEMBER 23, 2001

3. Time of Death: 5:30 AM

4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 219-34-8882

6. Sex: 1 ☐ M 2 ☐ F — X

7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 14, 1938

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X

10e. Street and Number: 11512 Ashley Drive

10f. Zip Code: 20852

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No — Specify:

14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Carpentry

17. Father's Name (First, Middle, Last): Charles F. Shaw

18. Mother's Name (First, Middle, Maiden Surname): Ruth Yost

19a. Informant's Name/Relationship (Type, Print): Mary Ellen Shaw, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11512 Ashley Drive, Rockville, MD 20852

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rosehill Cemetery

Date: Dec 27, 2001

20c. Location - City or Town, State: Clear Spring, Maryland

21. Signature of Funeral Service Licensee: Gary M. Sisi

22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

b. CHRONIC BRONCHITIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. SQUAMOUS CELL CARCINOMA, LUNG

Due to (or as a consequence of):

d. CHRONIC CIGARETTE SMOKER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

HYPERTENSION

HYPERLIPIDEMIA

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown — X

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W Gramina, M.D.

29c. License number: D21662

29d. Date signed (Month, Day, Year): 12-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILHELMINA CAMINA, M.D., 4912 ADRIAN STREET, ROCKVILLE, MD 20853

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Shaw, William 12/23/01 0530Hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42920

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James Edmund Shovlin	December 20, 2001	2:00P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
181-05-5212	1 [X] M 2 [ ] F	86 Yrs.			Sept 4, 1915	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12517 Atherton Drive	20906	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Telephone Repairman	Communications

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
James Joseph Shovlin	Mary Agnes Reith

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886
Margaret A. Shovlin/ Daughter	10305 Royal Woods Court, Montgomery Village, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metropolitan Crematory Dec 22, 2001	Alexandria, VA

21. Signature of Funeral Service Licensee: Eric S. Scerbo

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	9 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last b.	Arteriosclerotic Cardiovascular Disease	years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Cerebrovascular Accident

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Herman B Segal MD	MD 25808	12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herman B Segal MD 10313 Georgia Ave Silver Spring Md

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	Bernice G. Coates

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42921

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILAP SINGH

2. Date of Death Month / Day / Year: DEC. 22, 2001

3. Time of Death: 9:45 AM

4a. Facility Name *(If not institution, give street and number)*: MARINER HEALTH NURSING HOME

4b. City, Town, or Location of Death: KENSINGTON

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 218-92-2160

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APR. 21, 1909

9. Birthplace *(State or Foreign Country)*: INDIA

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 95 DAWSON AVE. #103

10f. Zip Code: 20850

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* INDIAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NEVER WORKED

16b. Kind of Business/Industry: NONE

17. Father's Name *(First, Middle, Last)*: LAL SINGH

18. Mother's Name *(First, Middle, Maiden Surname)*: JAMUNA DEVI

19a. Informant's Name/Relationship *(Type, Print)*: HARMOHINDAR SINGH/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15409 PEACH LEAF DR., N. POTOMAC, MD. 20878

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHAMBERS CREMATORY | Date: 12-23-01

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MO0091

22. Name and Address of Facility: 5801 CLEVELAND AVE., RIVERDALE, MD. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
- a. RESPIRATORY FAILURE — MINS.

Due to (or as a consequence of):
- b. END STAGE LEUKEMIA — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
- c. HYPERTENSION

Due to (or as a consequence of):
- d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vthertle Anthony

29c. License number: D0051158

29d. Date signed *(Month, Day, Year)*: DEC. 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VATTI ANTHONY, M.D. 2401 RESEARCH BLVD. #102, ROCKVILLE, MD. 20850

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 24 2001

32. Registrar's Signature: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42922

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Rogers Six
2. Date of Death (Month, Day, Year): December 17, 2001
3. Time of Death: 9:18 PM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 243-24-9505
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 28, 1924
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 735 Sligo Avenue
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Personnel Security Specialist
18b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Dennis F. Rogers
18. Mother's Name (First, Middle, Maiden Surname): Bessie Crumb

19a. Interment's Name/Relationship (Type, Print): Julia Cross/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 735 Sligo Ave., Silver Spring, MD 20910

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Dete: Dec 21, 2001
20c. Location - City or Town, Stete: Beltsville, MD

21. Signature of Funeral Service Licensee: Dennis A Sloody
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or heert teilure. List only one cause on each line.

Approximate Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Atherosclerotic Cardiovascular Disease — years

Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest

b. Hypertension — years

Due to (or es e consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings aveilable prior to completion of cause ot deeth? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the causa(s) and menner steted.

29b. Signatura and title of certifier:
29c. License number: 20391
29d. Date signed (Month, Day, Year): DECEMBER 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey A. Kelman, M.D. 6525 Belcrest Road, #208 Hyattsville, MD 20782

State Registrar

31. Dete filed (Month, Day, Year): DEC 24 2001
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42923

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Year	3. Time of Daath
HERMINA C. SMITH	DEC. 22, 2001	7:30 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Deeth
WASHINGTON ADVENTIST HOSPITAL	TAKOMA PARK	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplece (State or Foreign Country)
580-14-3015	1☐M 2☒F	79 Yrs.			NOV. 22, 1922	ANTIGUA, W.I.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
D.C.	NONE	WASHINGTON	1☒Yas 2☐No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
2608 HAMLIN ST. N.E.	20018	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Amaricen Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yas 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HEALTH AIDE WORKER	MENTAL PATIENTS

17. Father's Name (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Surname)
UNKNOWN	VIOLET VALENTINE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
IVES ROBERTS/SON	73 LEIGHTON RD., HYDE PARK, MA. 02136

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetary, cramatory or other place)	Deta	20c. Location - City or Town, State
1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	CHURCH YARD ST. PETER'S PARISH	1-3-2002	PARHAM, ANTIGUA, W.I.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
W. W. Chambers M00091	5801 CLEVELAND AVE., RIVERDALE, MD. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 20737

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not entar the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximata Intarval Batwean Onsat and Daath
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	TWO WEEKS
Sequentially list conditions, if any, leading to immedeate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or as a consequence of): b. URINARY TRACT INFECTION	TWO WEEKS
	Due to (or as a consequence of): c. SEPTICEMIA	TWO WEEKS
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Deta ol dalivary Month / Day / Year
1☐Yas 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

HYPERTENSION, DIABETESE MELLITUS, CEREBROVASCULER ACCIDENT

23a. Did tobecco use contributa to tha causa of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to complation of causa of daath?
1☐Yas 2☐No 3☐Probebly 4☒Unknown	1☐Yas 2☒No	1☐Yas 2☐No

25. Wes case referred to medical examiner?	26. Place of Daath (Check only ona)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Homa 5☐Residence 6☐Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yas 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Numbar or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred at the time, data and place, and dua to tha cause(s) end manner as steted.
2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date end placa, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
Saadullah Khan MD	D24011	12-22-2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) SAADULLAH KHAN MD
8830 CAMERON CT #403 SILVERSPRING MD 20910.

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Geneva G. Sorrell

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42924

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS F. SNOWDEN
2. Date of Death: Month DEC. Day 22 Year 2001
3. Time of Death: 7:15 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-40-2573
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 20, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Sandy Spring
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 17316 Dr. Bird Road
10f. Zip Code: 20860
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Reca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Manager
16b. Kind of Business/Industry: Montgomery County Public Schools

17. Father's Name (First, Middle, Last): Frederick Ricks
18. Mother's Name (First, Middle, Maiden Surname): Sadie Lee

19a. Informent's Name/Relationship (Type, Print): Thomas Snowden Jr/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17316 Dr. Bird Rd Sandy Spring, MD20860

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Norbeck Mem Park
Date: 12/28/2001
20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: Gene R. Snowden
22. Name and Address of Facility: Snowden Funeral Home P.A. 246 N Washington St Rockville, MD20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory Failure	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Lung CANCER	14 months
Due to (or as a consequence of):		
c.	Diabetes	
Due to (or as a consequence of):		
d.	Hyper tension	

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Garrett Reilly MD PhD
29c. License number: D39190
29d. Date signed (Month, Day, Year): December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Garrett Reilly, M.D. 3418 Olandwood Court, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,

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10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42925

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
KATHLEEN	FLORENCE	SMITH	December 19, 2001	11:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical Center	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
UNK	1 ☐ M 2 ☒ F	51 Yrs.			3-10-50	N.Y.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	WICOMICO	SALISBURY	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
723-MADISON STREET	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		DISABLED	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GEORGE CRUGG	MURIAL CRUGG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GEORGE A. AYDELOTTE - FRIEND	723-MADISON ST. SALISBURY, MD. 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	DOVER - CAPITOL	12/22/01	DOVER, DELAWARE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Necrotizing Fasciitis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivary Month / Dey / Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Matthew Warden	AV176435 W12433	12/20/1 8pm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Warden, 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42926

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HAROLD Sohl

2. Date of Death — Month: Dec Day: 13 Year: 2001

3. Time of Death: 1150

4a. Facility Name *(If not institution, give street and number)*: 8601 Veterans Highway

4b. City, Town, or Location of Death: Millersville

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-38-7466

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 4, 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1441 Grandview Road

10f. Zip Code: 21012

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4 or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Professor

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Theodore Sohl

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Sponsler

19a. Informant's Name/Relationship *(Type, Print)*: Glenn Sohl/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Mile 2 and Bryan Road Mission, Texas 78572

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 12/19/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Michael J. Dean

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Medical Parking Lot

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William P. Jones, Deputy MD

29c. License number: D06054

29d. Date signed *(Month, Day, Year)*: 12/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 2001

32. Registrar's Signature: Penny P Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42927

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LAVERN L. SULLIVAN
2. Date of Death Month Day Year: DEC. 16 2001
3. Time of Death: 0940 M
4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 216-78-6401
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN. 29 1957
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ANNAPOLIS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1802 LINCOLN DRIVE
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12th
College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HEALTH CARE WORKER
18b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name *(First, Middle, Last)*: CHARLES C. TURNER
18. Mother's Name *(First, Middle, Maiden Surname)*: ROSETTA WATKINS

19a. Informant's Name/Relationship *(Type, Print)*: ROSETTA GROSS (MOTHER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1802 LINCOLN DR. ANNAPOLIS, MARYLAND 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removet from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: EBENEZER AME CHURCH CEMETERY
Date: 12/21/01
20c. Location - City or Town, State: GALESVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Larry S. Reese M004483
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death)
a. Cerebrovascular Accident — Approximate Interval Between Onset and Death: 10day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Ruptured Giant Cerebral Artery Aneurysm — 10 days
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Recurrent Lymphoma

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: ▶ Brian Sullivan MD
29c. License number: D50954
29d. Date signed *(Month, Day, Year)*: 12/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian Sullivan, MD. 2002 Medical Pkwy Suite 430 Annapolis, Md. 21401

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 19 2001
32. Registrar's Signature: Denise D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42928

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Year	3. Time of Death
Hilton Stansbury Jr.	Dec 9 2001	1:30 PM

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Fairfield Nursing Center	Crownsville	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplece (State or Foraign Country)
219-64-8896	X 1 M 2 F	45 Yrs.			Jan 16 1956	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Anne Arundel	Glen Burnie	X 1 Yas 2 No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
305 T Oakwood Rd.	21061	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Raca - Amarican Indian, Black, White, atc.
1 Never Married 2 Married X 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	X 1 Yes 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th	0	Custodian	Hardees Restaurant

17. Father's Nama (First, Middle, Last)	18. Mother's Nama (First, Middla, Maiden Surnama)
Hilton Stansbury Sr.	Nola Henson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Phyllis Cook (Sister)	230-B Hilltop Lane #107 Annapolis, Md. 21403

20a. Method of Disposition	20b. Placa of Disposition (Nama of cemetery, crematory or other place)	Data	20c. Location - City or Town, Stata
X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Annapolis Memorial Gardens	12-17-01	Annapolis, Md.

21. Signature of Funeral Service Licensee: ▶ Harry D. Reese M00482

22. Nama and Address of Facility: Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Auto immun deficiency Syndrome — Approximate Intarval Batwaen Onset and Death: 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Human immun deficiency Virus infection — 1 year

Due to (or as a consequanca of):

c. _____

Due to (or as a consequanca of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcoma of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____ 9 Unknown

23d. Date of dalivary: Month / Day / Year

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of daath? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yas 2 X No

24b. Wara autopsy findings availabla prior to completion of causa of daath? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Placa of Daath (Check only ona)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Othar: 4 X Nursing Home 5 Rasidanca 6 Othar (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1 Yas 2 No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, straet, factory, offica building, atc. (Specify)

28f. Location (Street and Numbar or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurrad at tha time, data and placa, and due to the causa(s) and manner as steted. 2 **Medical Examiner:** On the basis of axaminetion and/or investigation, in my opinion, death occurrad at tha tima, data and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶ MD	D38958	12/10/2001

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print): Dalpat Singh Sidhu 1413 Annapolis Road #106 Odenton MD 21113

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
DEC 12 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42929

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Florence May Trivette	December 23, 2001	6:55 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital Center	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217 32 4358	1☐ M 2☒ F	64 Yrs.			April 7, 1937	Washington, DC

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	Clinton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8200 Woodyard Road	20735	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	Home Security

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John T. Hook	Gladys Timmons

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gladys Hook-Sister	4921 Seminary Road #604, Alexandria, VA 22311

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Northern VA Funeral Services	12-29-01	Chantilly, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Evin Thomas Rouse Jr	Northern Virginia Funeral Services 14522L Lee Road, Chantilly, VA 20151

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis

Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cor Pulmonale

Due to (or as a consequence of):
d. Alcoholic Liver Dis.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	D45630	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Arnold Bonaventure MD 6404 S. Osceola Hwy Upper Marlboro MD 20772

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Florence Trivette expired 12-23-01 @ 6:55pm

CR (2)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No 2001 42930

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Reginald Edward Talbert
2. Date of Death — Month: December Day: 20 Year: 2001
3. Time of Death: 11:00AM
4a. Facility Name *(If not institution, give street and number)*: Heartland Health Care Center
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-16-8791
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 30, 1914
9. Birthplace *(State or Foreign Country)*: Wash., DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 400 Old Stone Road
10f. Zip Code: 20904
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* African American
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 11th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Government Employee
16b. Kind of Business/Industry: Government
17. Father's Name *(First, Middle, Last)*: James L. Talbert, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Johnson
19a. Informant's Name/Relationship *(Type, Print)*: Preston T. Talbert - Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 400 Old Stone Rd, Silver Spring, MD 20904
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Quantico National Cem.
Date: 12/28/2001
20c. Location - City or Town, State: Triangle, VA
21. Signature of Funeral Service Licensee: John T. Stewart III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia, End Stage
Osteoperosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)* — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residance 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*
29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D01852
29d. Date signed *(Month, Day, Year)*: December 26, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A. DeVore, M.D. 4203 Queensbury Rd., Hyattsville, MD 20781

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 27 2001
32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

6

DEC 5 4 500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #2&20b PER FH G803 1/16/02 #17&18 jb

Certificate of Death

Reg. No. 2001 42931

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Helen Y. Thompson	12 / ~~12~~ 21 / 2001	5:28PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gladys Spellman Nursing Home	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
168-24-4658	1☐M 2☐F	69 Yrs.			3/25/1932	Steelton, PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Mitchellville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12304 Prospect Landing	20721	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Training Manager	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Vitko ~~Yovanovic~~ YOVANOIC	Violet ~~Doerpa~~ DERPA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Melvin G. Thompson/ Husband	12304 Prospect Landing Mitchellville, MD 20721

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	20b. Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	~~Presbyterian Church~~ EWING CHURCH ~~Cemetery~~	12/29/01 ~~12/28/01~~	Ewing, NJ

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. D. Marshall	J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infraction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Cerebral Hemorrhage	
	c. Due to (or as a consequence of): Hypertension	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause ol death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ Ophnell Cumberbatch	D27577	12/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ophnell Cumberbatch, M.D. 2900 Mercy Lane, Cheverly, MD 20785

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(20)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

DEC 3 1 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42932

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Corinne Betty Taylor
2. Date of Death: Month December Day 27 Year 2001
3. Time of Death: 7:45 a M
4a. Facility Name (If not institution, give street and number): 11218 Lakeview Drive
4b. City, Town, or Location of Death: Dunkirk
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 578 20 5461
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 4, 1925
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert
10c. City, Town or Location: Dunkirk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11218 Lakeview Drive
10f. Zip Code: 20754
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): office manager
16b. Kind of Business/Industry: pharmacy

17. Father's Name (First, Middle, Last): George Sollers
18. Mother's Name (First, Middle, Meiden Sumeme): Flora Travers

19a. Informant's Name/Relationship (Type, Print): Joyce A. Wood (daug.)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1221 Harmony Lane, Owings, MD 20736

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Southern Mem. Gardens | Date: 12-31-01
20c. Location - City or Town, State: Dunkirk, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DIABETES — Approximate Interval: YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: 029657
29d. Date signed (Month, Day, Year): 12/28/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES JUDGE, M.D. Prince Frederick, Md 20678

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42933

MILTON TALBOTT 213-24-3971

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
MILTON	MASON	TALBOTT	Dec. 21 2001	0814 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-24-3971	1 X M 2 F	74 Yrs.			08/26/1927	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Somerset	Deal Island	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23135 Harrison Road	21821	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: 1945-1946	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	none	Letter Carrier	Post Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edgar Mason Talbott	Agnes Phelps

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Glendis White Talbott/Wife	23135 Harrison Road, Deal Island, MD 21821

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Salisbury Crematory	12/23/01	Salisbury, MD

21. Signature of Funeral Service Licensee: [signature] M00295

22. Name and Address of Facility: Hinman Funeral Home, 11673 SomersetAve., Princess Anne, MD 21853

Physician /Medical Examiner — Medical Certification; To Be Completed by Physician/Medical Examiner

22a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC LUNG CANCER — 6 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE LUNG DISEASE

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

28. Place of Death (Check only one): Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature], MD	D 046962	DECEMBER 21, 2001.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICAL CENTER. MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

DEC 3 2001

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42934

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
JULIAN C. TYLER	December 25, 2001	0659 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-52-9219	1☒M 2☐F	70 Yrs.			November 20, 1931	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Somerset	Crisfield	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
118 N. Somerset Avenue	21817	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 2/7/52 To 2/29/72	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Manager	City of Crisfield, MD

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Norman T. Tyler	Lillian Middleton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mark Tyler (Son)	27142 Coach House Lane- Salisbury, MD 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sunnyridge Memorial Park	12/28/01	Crisfield, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert H. Bradshaw, Jr.	Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21817

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardio pulmonary arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Emphysema	
	Due to (or as a consequence of): c. Acute Myocardial Infarction	
	Due to (or as a consequence of): d. Renal Failure	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Ramesh K. Agarwal	D54807	DECEMBER 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMESH AGARWAL, M.D. 1315 S. DIVISION ST. SALISBURY, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

579-52-9219

Julian Tyler

15

DEC 8 1980

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42935

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dylan Tiller	December 17, 2001	7:42P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1[X] M 2[ ] F	Yrs.		1	Dec 17, 2001	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Bethesda	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10423 Montrose Avenue, #104	20814	N/A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ed Tiller	June E. Sherry

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ed Tiller & June Sherry /S (parents)	10423 Montrose Road #104, Bethesda, MD 20814

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Gate of Heaven Cemetery	Dec 22, 2001	Silver Spring, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John E. Parker	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypoxia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Prematurity	
	Due to (or as a consequence of):	
	c. Preterm labor - twin gestation	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[X] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Karen B. Feibus MD (For Dictation)	D 0054141	12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Karen B. Feibus, MD 15215 Shady Grove Road, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Geneva G. Lewis

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42936

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Edward Bruce Tomlinson	December 24, 2001	10:10 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	8. Sex	7. Age (If yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
095-28-1147	X 1 M 2 F	65 Yrs.			Mar 30, 1936	New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13212 Turkey Branch Parkway	20853	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Mechanical Engineer	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Tomlinson	Helen Clanton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Monika Tomlinson / Wife	13212 Turkey Branch Parkway, Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Metropolitan Crematory	Dec 27, 2001	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Francis J. Scarlo	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gastrointestinal Bleeding	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Peptic Ulcer Disease	
	Due to (or as a consequence of):	
	c. Renal Failure	
	Due to (or as a consequence of):	
	d. Dehydration	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bladder Carcinoma

Septic Shock from Urinary Tract Infection

Deep Vein and Thrombophlebitis

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

28. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Robert H Gerard MD	MD#D0055522	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT H GERARD MD 1500 Forest Glen Rd Silver Spring, Maryland 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 42937

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Benjamin B. Trillanes
2. Date of Death Month Dey Year: December 21, 2001
3. Time of Death: 12:00 PM
4e. Facility Neme *(If not institution, give street and number)*: 3814 Decatur Avenue
4b. City, Town, or Location of Deeth: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-05-4739
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Houra / Min.
8. Dete of Birth *(Month, Dey, Year)*: Mar 21, 1907
9. Birthplaca *(Stete or Foreign Country)*: Phillipines

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3814 Decatur Avenue
10f. Zip Code: 20895
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes: 1943-1945
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Reca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Bartender
16b. Kind of Business/Industry: Food

17. Fether's Neme *(First, Middle, Last)*: Jose Trillanes
18. Mother's Name *(First, Middle, Meiden Surneme)*: Maria Babao

19e. Informent's Neme/Relationship *(Type, Print)*: Irene Trillanes / Wife
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3814 Decature Avenue, Kensington, MD 20895

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: Maryland Veteran's Cemetery
Dete: Jan 2, 2002
20c. Location - City or Town, State: Cheltenham, MD

21. Signeture of Funeral Service Licensee: ▶ Andrew J. Cole
22. Neme end Address of Feciliby: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)
a. Coronary artery disease — Due to (or es e consequenca of): — years

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last
b. — Due to (or es e consequenca of):
c. — Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 [X] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: ▶ Patricia L. Tomsko, MD
29c. License number: 051916
29d. Date signed *(Month, Dey, Year)*: December 24, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, #348, Rockville, MD 20852

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 27 2001
32. Registrar's Signeture: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

GE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3+1yr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42938

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
ALBERT A TROIANO	DECEMBER 23, 2001	11:30 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-64-0432	1☒ M 2☐ F	46 Yrs.					JUNE 17, 1955	WASHINGTON, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	GAITHERSBURG	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
25025 WOODFIELD SCHOOL ROAD	20882	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		TILE/ MARBLE SETTER	CONSTRUCTION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
EMILIO TROIANO	ANNA VANLENGEN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANNA TROIANO (MOTHER)	25025 WOODFIELD SCHOOL RD, GAITHERSBURG MD 20882

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	FORT LINCOLN CEMETERY	12-28-01	BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kevin Gutierrez	HINES RINALDI FUNERAL HOME INC 11800 NEW HAMPSHIRE AVE, SILVER SPRING MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. VENTRICULAR FIBRILLATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Dey, Year)
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	51280	12-24-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANOUSHIRAVAN DADGHAR 9901 MEDICAL CENTER DRIVE, ROCKVILLE MARYLAND 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42939

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Devin Tiller

2. Date of Death (Month, Day, Year): December 17, 2001

3. Time of Death: 2:40 P M

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: N/A

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min. 10

8. Date of Birth (Month, Day, Year): Dec 17, 2001

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10423 Montrose Road #104

10f. Zip Code: 20814

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 0

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Neme (First, Middle, Last): Ed Tiller

18. Mother's Neme (First, Middle, Meiden Surneme): June E. Sherry

19a. Informant's Name/Reletionship (Type, Print): Ed Tiller & June Sherry / (parents)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10423 Montrose Road, #104, Bethesda , MD 20814

20a. Method ot Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Gate of Heaven Cemetery

Dete: Dec 22, 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: John E. Parker

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Hypoxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Prematurity

Due to (or as a consequence of):

c. Preterm Labor — Twin gestation

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time ot deeth 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case relerred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2 [ ] **Medical Exeminer:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Feibus MD (for Dickman)

29c. License number: D 0054141

29d. Date signed (Month, Dey, Year): 12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karen B. Feibus , MD 15215 Shady Grove Road, Rockville, MD 20850

State Registrar

31. Date filed (Month, Dey, Year): DEC 28 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 42940

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Terry
2. Date of Death Month Day Year: December 22, 2001
3. Time of Death: 1:00 PM
4a. Facility Name *(If not institution, give street and number)*: Sunrise House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-48-4292
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 2, 1918
9. Birthplace *(State or Foreign Country)*: China

Usual Residance of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Locafion: Rockville
10d. Inside City Limifs: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4824 Aspen Hill Road
10f. Zip Coda: 20853
10g. Citizen of Whet Countfy?: USA

11. Marifal Sfafus: 1 [X] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Americen Indian, Black, Whita, atc. *Specify:* White
15. Decedent's Educefion *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dispatcher
16b. Kind of Businass/Industry: Trucking Company
17. Fathar's Nama *(First, Middle, Last)*: Bertram Terry
18. Mother's Nama *(First, Middle, Maiden Surname)*: Yoma Sato
19a. Informant's Name/Relationship *(Type, Print)*: Jerry Jump / Half-Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4824 Aspen Hill Road, Rockville, MD 20853
20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Data: Dec 24, 2001
20c. Location - City or Town, Stata: Alexandria, VA
21. Signatura of Funaral Service Licensee: Kevin K. Thomas
22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enfar tha disease, or complfcations that caused tha daath. Do not enfar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart faitura. List only ona causa on aach line. — Approximata Interval Batwaen Onsat and Death

Immediate Cause (Final disease or condition resulting in daath)
a. Failure To Thrive
Dua to (or as a consaquanca of):
Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in death) Last
b. Pneumonia
Due fo (or as a consaquanca of):
c. Dehydration
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco uas contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of causa of daath? 1 [ ] Yas 2 [X] No

25. Was casa rafarrad to madical axaminar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA | Other: 4 [X] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Manner of Daath: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowladga, daath occurrad at the time, data and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examinafion and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and fitla of certifier:
29c. Licansa number: D48200
29d. Data signed *(Month, Day, Year)*: December 24, 2001

30. Nama and addrass of parson who complatad causa of death (Item 23a) (Type, Print): David Anders, MD 8824 Cunningham Drive, #B, Berwyn Heights, MD 20720

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 26 2001
32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42941

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
HELEN TENENBAUM	DECEMBER 18, 2001	3:28P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
130-24-1538	1☐M 2☒F	83 Yrs.			08/13/1918	"UNKNOWN"

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	SILVER SPRING	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1316 FENWICK LANE #410	20910	UNITED STATES OF AMERICA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
"UNKNOWN"		"UNKNOWN"	"UNKNOWN"

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MOSE FINE	SUE CRENBLETH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RIGGS BANK/POA	808 17th STREET, NW, WASHINGTON, D.C. 20006

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METRO CREMATORY	12/22/2001	ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. UPPER GASTROINTESTINAL HEMORRHAGE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

TYPE TWO DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D43228	DECEMBER 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. POSORSKE, LYNTTE, 6121 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	[signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42942

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
BERNICE LEONA TALLERICO	December 25 2001	12:07p

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
DOCTOR'S HOSPITAL	LANHAM	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
171-22-0468	1☐ M 2☒ F	74 Yrs.			SEPT. 15, 1927	PA.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	PRINCE GEORGES	RIVERDALE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5908 60th AVE.	20737	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		HOMEMAKER	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FOREST EDWARD WOOMER	ELLEN RUTH MOORE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DAVID TALLERICO/SON	5908 60th AVE., RIVERDALE, MD. 20737

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CHAMBERS CREMATORY	12-26-2001	RIVERDALE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ W. W. Chambers MO0091	5801 CLEVELAND AVE., RIVERDALE, MD. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 20737

To Be Completed by Funeral Director

Bernice L Tallerico

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Mary

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Terminal lung cancer	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Pinolvan Limpaungthip	D 20196	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PINOL LIMPAUNGTHIP, MD 9721 BULL POINT DRIVE, GREENBELT, MD 20770

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42943

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: M. Genevieve Taylor
2. Date of Death Month / Dey / Year: December 25 2001
3. Time of Death: 2 P.M.
4a. Facility Name *(If not institution, give street and number)*: Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-32-6243
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: May 5, 1910
9. Birthplace *(Stete or Foreign Country)*: N. Dakota

Usual Residence of Decedent

10a. Stete: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 415 Russel Avenue #419
10f. Zip Code: 20877
10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Budget Analysis
16b. Kind of Business/Industry: Federal Government

17. Fether's Neme *(First, Middle, Last)*: James Taylor
18. Mother's Neme *(First, Middle, Meiden Surname)*: Carrie Quick

19e. Informent's Neme/Reletionship *(Type, Print)*: Sydna Zeliff/ Niece
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1131 Kittiwake Drive, Venice, FL 34292

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Cremetory — Date: December 26,2001
20c. Location - City or Town, Stete: Alexandria , Virginia

21. Signeture of Funerel Service Licensee: Tracy A. Stuber
22. Neme end Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. — Approximete Interval Between Onset and Deeth

Immediete Cause (Final disease or condition resulting in death): a. Carcinomatosis

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last:
b. Metastatic Ovarian Carcinoma
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other sfgnificant conditfons** contributing to death but not resulting in the underlying ceuse given in Pert I.: Renal Failure, Congestive heart Failure, Diabetes II, Hypertensive cardiovascular Disease, Peripheral neuropathy from chemotherapy

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed?: 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death?: 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer?: 1☐ Yes 2☒ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: H. Robert Birschbach, M.D.
29c. License number: D04115
29d. Date signed *(Month, Day, Year)*: December 26, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Typa, Print): H. Robert Birschbach, M.D., 201 Russell Avenue, Gaithersburg, MD 20877

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001
32. Registrer's Signeture: Denise B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 410-764-3613

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42944

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Earlene Umstead

2. Date of Death Month Day Year: December 20, 2001

3. Time of Death: 7:30 AM

4a. Facility Name *(If not institution, give street and number)*: 4221 Garnet Drive

4b. City, Town, or Location of Death: Middletown

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 578-28-1384

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 23, 1926

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 4101 Spruell Drive

10f. Zip Code: 20895

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yaa 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): - ; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Administrative Assistant

16b. Kind of Business/Industry: Montgomery Mental Health Association

17. Father's Name *(First, Middle, Last)*: Lloyd Jennings Jones

18. Mother's Name *(First, Middla, Maidan Sumema)*: Etta Mae Harris

19a. Informent's Name/Ralationship *(Type, Print)*: Brooke A. Good/ Daughter

19b. Malling Address *(Street end Number or Rurel Route Number, City or Town, Stata, Zip Code)*: P.O. Box 418, Ocean View, Delaware 19970

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or othar piece)*: Montgomery Crematorium, Inc.

Data: December 22, 2001

20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signature of Funaral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock or heart failure. List only one ceuse on eech line.

Approximete Intarval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. Squamous Carcinoma of the lung — Months

Due to (or es e consequence of):

b. Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c. Bladder Cancer

Dua to (or as a consequance of):

d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Diabetes Mellitus

Atrial Fibrillation

Deep Vein Thrombosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidance 6☒ Othar *(Specify)* Daughter's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be detarmined

28a. Data ot Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier

29c. License number: D47169

29d. Dete signed *(Month, Dey, Year)*: December 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chan Hing Ma Ho, M.D., 610 Ninth Avenue, Brunswick, Maryland 21716

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 26 2001

32. Registrar's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42945

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Daniel Vasvery

2. Date of Death (Month, Day, Year): December 24, 2001

3. Time of Death: 9:30 P M

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-42-1295

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-03-1911

9. Birthplace (State or Foreign Country): Corning, Ohio

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1402 Moffet Rd.

10f. Zip Code: 20903

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seed Analyst

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): John Vasvery

18. Mother's Neme (First, Middle, Meiden Surname): Kathryn Vasvery

19a. Informant's Name/Relationship (Type, Print): Geneva Logan/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9624 Dilston Rd. Silver Spring, MD 20903

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gate of Heaven Cem.

Date: 12/29/2001

20c. Location - City or Town, Stete: Silver Spring, MD

21. Signeture of Funeral Service Licensee: K. E. W.

22. Name and Address of Feciility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cereberal Vascular Accident — < 30 min

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Hypertension
Diabetes

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [X] Unknown

24a. Was an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner es stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Zeya M.D. Attending M.D. E.R.

29c. License number: D44848

29d. Date signed (Month, Day, Year): 12/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Humayun Zeya; Emergency Department Washington Adventist Hospital 7600 Carroll Av. Takoma Park M.D.

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Bruce G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42946

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Barbara Watt Voitel	December 22, 2001	1:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
105-32-8896	1☐M 2☒F	61 Yrs.			Oct. 30, 1940	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Germantown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13920 Wanegarden Drive	20874	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Software Engineer	Aerospace

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Machray Daniels	Evelyn Bowers Watt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William W. Daniels/Brother	274 Tolstoy Lane, Severna Park, Maryland 21146

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Montgomery Crematorium	December 26, 2001	Bethesda, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M00198	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: Minutes

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d. Chronic Obstructive Pulmonary Disease

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D54635	December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Cetta, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

01-7049-003
B.K.S
THOMAS VOGEL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42947

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Frederick Vogel
2. Date of Death (Month, Day, Yaar): DEC. 13, 2001
3. Time of Death: 2340 PM
4a. Facility Name *(If not institution, giva street and number)*: NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Deeth: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 218-82-8526
6. Sax: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 42 Yrs. — If Under 1 Yaar: Months / Deys — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: Jul 27, 1959
9. Birthplace *(Stete or Foraign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐Yes 2☒No
10a. Streel and Number: 150 Inverness Road
10f. Zip Code: 21146
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐Nevar Merried 2☐Merried 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Datas:
13. Was Decedenl of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐Yes 2☒No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 11 — College (1-4or 5+):
16a. Decedant's Usuel Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Carpenter/Tradesman
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Unavailable
18. Mother's Name *(First, Middla, Maidan Sumame)*: Unavailable

19a. Informant's Name/Relationship *(Type, Print)*: Karen Unger/Friend
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 209 Crest Circle, Pasadena, MD 21122

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory
Date: Dec 14
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas E Allen
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Batween Onset and Death

Immediale Cause (Final diseasa or condition resulting in death): a. MULTIPLE INJURIES
Due to (or as e consequenca of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es e consequenca of):
c.
Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributa to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☒Yas 2☐No
24b. Were eutopsy findings available prior to completion of causa of death? 1☐Yas 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*
27. Menner of Deeth: 1☐Naturel 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury *(Month, Dey Year)*: 12/13/01
28b. Tima of Injury: 2220 M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: EJECTED DRIVER OF CAR WHICH STRUCK A FIXED OBJECT
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: ROADWAY
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: ROUTE 2 AND EASTWAY DRIVE

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier:
29c. Licansa number: O.C.M.E
29d. Date signed *(Month, Dey, Year)*: DEC. 14, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple MD. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Dey, Year)*: DEC 18 2001
32. Registrar's Signatura: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

AMEND #10e, 20c, 1/2/02, BMW, Mtg

2001 42948
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rebecca Carlotta Woodson
2. DATE OF DEATH (Month, Day, Year): December 21, 2001
3. TIME OF DEATH: 11:45 PM M
4. SOCIAL SECURITY NUMBER: 217-38-9016
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 62 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 8, 1939
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Woodside Center
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: D.C.
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Washington
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1210 ~~Flora~~ Floral Street, N.W.
10f. ZIP CODE: 20012
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Negro
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Andrew Clifton Woodson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie Lundy
19a. INFORMANT'S NAME (Type/Print): Andrew Woodson Brother
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6319 38th Avenue, S.W., Seattle, WA 98126
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Chesapeake Crematory — DATE: 1/2/02
20c. LOCATION — City or Town, State: Beltsville, ~~ME~~ MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: André Thompson
22. NAME AND ADDRESS OF FACILITY: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Wash. D.C. 20012

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic uterine Sarcoma	few months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Amendhirath MD
29c. LICENSE NUMBER: D38262
29d. DATE SIGNED (Month, Day, Year): ▶ Dec 25, 2001

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr A MENDHIRATTA 2401 Research BLVD Suite 340 Rockville MD 20850

12

31. DATE FILED (Month, Day, Year): DEC 28 2001
32. REGISTRAR'S SIGNATURE: Geneva G. Lewis

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42949

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
MARY	ANNE	WINDSOR	DECEMBER 19, 2001	23:55 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MONTGOMERY GENERAL HOSPITAL	OLNEY	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579 12 0460	1☐M 2☒F	81 Yrs.			AUG. 25, 1920	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	MONTGOMERY	SILVER SPRING	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12211 EDGEMONT STREET	20902	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	CLERK	INSURANCE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LOUIS E. PAYNE	HAZEL A. RICHARDS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
TIMOTHY C. PRICE, ATTORNEY	33 WOOD LANE, ROCKVILLE, MD. 20850

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	PARKLAWN CEMETERY	1/3/02	ROCKVILLE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Muriel H. Barber	MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATORY FAILURE	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. FLUID OVERLOAD	1 week
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE DUE to POLYCYSTIC KIDNEY DISEASE

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Barry Keehn, MD	D19192	December 20, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
BARRY KEEHN, MD, 3941 FERRARA DRIVE, WHEATON, MARYLAND 20906

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 24 2001	▶ Geneva D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42950

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEONG K. WAIN
2. Date of Death (Month, Day, Year): DECEMBER 22, 2001
3. Time of Death: 22:30 P M
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577 76 5870
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 103 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 21, 1898
9. Birthplace (State or Foreign Country): CHINA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8240 HAWKINS CREAMERY ROAD
10f. Zip Code: 20882
10g. Citizen of Whet Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed): Elemeptary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER
18b. Kind of Business/Industry: LIQUOR STORE

17. Father's Name (First, Middle, Last): LEONG S. PAK
18. Mother's Name (First, Middle, Maiden Surname): (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): MYA AYE KYI, DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8240 HAWKINS CREAMERY ROAD, GAITHERSBURG, MD. 20882

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY
Dete: 12/26/01
20c. Location - City or Town, State: ALEXANDRIA, VA.

21. Signature of Funerel Service Licensee: Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY ARREST — MINUTES

Due to (or as a consequence of):
b. ATHEROSCLEROSIS — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)
Hospitel: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D0054139
29d. Date signed (Month, Day, Year): DECEMBER 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DUC LE, M.D. 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD. 20850

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Geneva B. Scott

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42951

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mildred Bernice Weakley	December 20, 2001	9:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
13822 Leibig Road	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-18-8245	1☐M 2☒F	81 Yrs.			Oct. 2, 1920	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13822 Leibig Road	20904	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lloyd Wesley Jones	Ruth Virginia Smallwood

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley Roesemann / Daughter	P.O. Box 772682, Ocala, FL 34477

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify)	Parklawn Memorial Park	Dec. 22, 2001	Rockville, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. CF

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Gastric Cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Jeffrey Drobis	MD 18137	December 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeffrey Drobis, M.D. 12201 Plum Orchard Drive, Silver Spring, MD 20904

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42952

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DIANNA L. WHEELER
2. Date of Death (Month, Day, Year): December 24, 2001
3. Time of Death: 4:35 P M
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-78-9863
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 28, 1961
9. Birthplace (State or Foreign Country): Washington, D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19109 Bloomfield Road
10f. Zip Code: 20832
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None-Never worked, disabled
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Jerry L. Wheeler
18. Mother's Name (First, Middle, Maiden Surname): Glenna E. Edwards

19a. Informant's Name/Relationship (Type, Print): Jerry L. Wheeler / Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19109 Bloomfield Rd., Olney, Maryland 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Norbeck Memorial
Date: 12/29/01
20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: Muriel A. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. SARCOIDOSIS — Approximate Interval Between Onset and Death: 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. CROHN'S DISEASE — 20 years
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John E Herring MD
29c. License number: D 30414
29d. Date signed (Month, Day, Year): 12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN HERRING MD 18101 Prince Philip DR OLNEY MD.

State Registrar

31. Date filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Jennie G. Noelke

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42953

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Meriam S. WILLIAMOWSKY	December 23, 2001	8:00 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Casey House Montgomery Hospice	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-28-1083	1☐M 2☒F	78 Yrs.			Dec. 25, 1922	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15101 Interlachen Drive #523	20906	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	Private Industry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Sandler	Rebecca Band

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Larry Williamowsky, Son	13828 Lambertina Place, Rockville, MD 20850

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	King David Memorial Garden	12/26/01	Falls Church, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Torchinsky Hebrew Funeral Home, Inc. 254 Carroll Street, NW, Washington, DC 20012

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Intra Cranial Hemmorhage	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Chitra Rajagopal	D 42452	December 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Chitra Rajagopal 18111 Prince Philip Drive #327, Olney, MD 20832

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42954

Pt known as Richard Watkins, JR

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Watkins, Jr.
2. Date of Death (Month, Day, Year): December 13 2001
3. Time of Death: 839 AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore,
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-40-3741
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4 10 43
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 7422 Rockridge Road
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Equipment Operator
16b. Kind of Business/Industry: Industrial

17. Father's Name (First, Middle, Last): Richard Watkins, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Green

19a. Informant's Name/Relationship (Type, Print): Edith Watkins-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7422 Rockridge Rd Balto., MD 21208

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chews Memorial
Date: 12/18/01
20c. Location - City or Town, State: Owensville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Miller's Metropolitan Chapel 1922 Forest Dr. Annapolis, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Septic Shock	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Human Immunodeficiency Virus
Renal Failure
Diabetes Mellitus Type II

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kinjal A. Nanavati MD
29c. License number: Res-001
29d. Date signed (Month, Day, Year): 12/13/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sinai Hospital of Baltimore Kinjal A. Nanavah

State Registrar

31. Date filed (Month, Day, Year): DEC 19 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42955

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MILDRED L WEBER

2. Dete of Death Month: DEC. Day: 12, Year: 2001

3. Time of Death: 1:30 AM

4a. Facility Neme *(If not Institution, give street end number)*: Annapolis Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-48-6482

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: March 3, 1915

9. Birthplece *(State or Foreign Country)*: Washington, DC

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 113 Pinecrest Drive

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): College (1-4or 5+): +2

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: Hadley Harbour

18. Mother's Name *(First, Middle, Maiden Surneme)*: Mildred L. Proctor

19a. Intormant's Neme/Reletionship *(Type, Print)*: Katherine Brandon (friend/POA)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 113 Pinecrest Dr. Annapolis, Maryland 21403

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: Baltimore Crematory

Dete: 12/13/2001

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Todd E. Lillie

22. Neme end Address of Feclity: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert teilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in deeth):

e. ASPIRATION PNEUMONIA — 3wks

Due to (or as e consequenca of):

b. ALTZHEIMERS DEMENTIA — 10 YEARS

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last

Due to (or es a consequence ot):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert i.: SACRAL AND LEFT POPLITEAL DECUBITI

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy tindings eveileble prior to completion ot cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner ot Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece ot Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end manner steted.

29b. Signeture and title ot certifier: Wesley Hammond

29c. License number: D23450

29d. Date signed *(Month, Day, Year)*: 12-12-01

30. Neme and address of person who completed cause ot deeth (Item 23a) (Type, Print): WALTER HEPNER 11403 KAUFFELL DR SUITE F OWINGS MILLS 21117

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 13 2001

32. Registrer's Signeture

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #29c.& 30.Per Phys.PGC 12-28-01 cr

Certificate of Death

Reg. No. 2001 42956

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
PAULINE	WALLACE	December 14, 2001	6:49 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months / Deys	If Undar 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplace (Stete or Foreign Country)
577-18-0263	1☐ M 2☒ F	89 Yrs.			Feb. 26, 1912	North Carolina

Usuel Resldence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.	N/A	Washington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
401 K St. N.W. #726	20001	USA

11. Marital Status	12. Wes Decedant Evar in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.)	14. Rece - American Indian, Black, Whita, atc.
1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detas:	1☐ Yas 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupetion (Giva kind of work dona dunng most of working life. DO NOT use ratired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	4 yrs	Accountant	Industrial Bank

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Sumame)
Thomas Walker Wallace	Lauretta Julia Lawson

19a. Informant's Neme/Reletionship (Type, Print)	19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Laura Covington/Niece	16001 Amina Dr. #2 Burtonsville, Md. 20866

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Gate of Heaven	12-17-01	Silver Spring, Md.

21. Signature of Funaral Service Licensee: J. P. Marshall

22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immedieta Cause (Finel diseasa or condition resulting in death)	a. UROSEPSIS	48 Hours
	Due to (or es e consequence of):	
Sequentially fist conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest	b.	
	Due to (or as e consequence of):	
	c.	
	Dua to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of causa of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	D0053337 ~~D31563~~	December 14, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)
~~Charles H. Benner,~~ DOROTHY SEAY, M D 11251 Lockwood Drive Silver Spring, MD 20901

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(6)

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Sandra B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42957

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice Wood

2. Date of Death (Month, Day, Year): December 20, 2001

3. Time of Death: 1911

4a. Facility Name (If not institution, give street and number): Prince George's Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 238-82-1346

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-16-1946

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedant

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10260 Prince Place

10f. Zip Code: 20774

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Substitute Teacher

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Willie Deans

18. Mother's Name (First, Middle, Maiden Surname): Virginia Bullock

19a. Informant's Name/Relationship (Type, Print): Charles E. Wood/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10260 Prince Place, Upper Marlboro, MD. 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Harmony Memorial Park

Date: 12/29/01

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: ▶ K. D. Marshall

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 20785

CR

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Salvador Sylvester, DO

29c. Licensa number: H0055727

29d. Data signed (Month, Day, Year): December 29, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive Cheverly, Maryland 20785

State Registrar

31. Data filed (Month, Day, Year): DEC 27 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6

DEC 5 A 508

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #5 PER FH G809 7/25/02 JH

Certificate of Death

Reg. No. 2001 42958

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Emma	E.	White	December 26, 2001	1:25 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~219-28-3444~~ ~~578-07-2244 (D)~~	1☐ M 2☒ F	90 Yrs.			Dec. 7, 1911	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Clinton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9701 Wagner Trail	20735	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th	N/A	Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Cross	Mary Irene Fowler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Myrtle E. Richards (Cousin)	8411 Dangerfield Road Clinton, Maryland 20735

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Christ Episcopal Ch. Cem. 2001	Dec. 29	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ H. E. Lee	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

CR 12-26-01 @ 1:25AM

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	2 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D19431	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank A. Ryan MD 11704 Livingston Rd #205 Ft. Washington MD 20744

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

EMMA White expired 12-26-01 @ 1:25AM

(4)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42959

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James A. Wood	December 18, 2001	8:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7002 Greeley Rd.	Landover	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-28-8140	1☒ M 2☐ F	70 Yrs.			7/22/1931	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Landover	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7002 Greeley Rd.	20785	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Stamp Examiner	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Oden Wood	Irene Brooks

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rose Woods/Wife	7002 Greeley Rd. Landover, MD 20785

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Lincoln Memorial Park	12-26-2001	Suitland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ K. D. Marshall	JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the diseese or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Lung Cancer	32 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or es a consequence of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnency 4☐ Pregnent et time of deeth 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☐ No 3☒ Probebly 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Mutombo Kankonre, MD	D46704	December 21, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
Mutombo Kankonre, Kaiser Permanente 1221 Mercantile Lane Largo, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DEC 5 1 5001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42960

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: ELVETA R. WASHINGTON
2. Dete of Deeth Month Dec. Day 22, Year 2001
3. Time of Death: 8:30 PM
4e. Fecility Neme *(If not institution, give street end number)*: Heartland Health Care Center-Adelphi
4b. City, Town, or Location of Deeth: Adelphi
4c. County of Deeth: Prince George

Funeral Director

5. Sociel Security Number: 578-20-5835
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: April 12, 1917
9. Birthplece *(Stete or Foreign Country)*: North Carolina

Usuel Residence of Decedent

10e. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6104 Tyburn Street
10f. Zip Code: 20748
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 9 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Laundress
16b. Kind of Business/Industry: Private
17. Fether's Neme *(First, Middle, Last)*: Unavail
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Stella Gaye
19e. Informent's Neme/Reletionship *(Type, Print)*: (Niece) Shirley H. Pendergast
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1818 24th St.,N.E.#202(Wash.,D.C.20002)
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: Resurrection Cemetery — Dete: 12/29/01 — 20c. Location - City or Town, Stete: Clinton, Md.
21. Signeture of Funerel Service Licensee: D.S. Jordan
22. Neme end Address of Fecility: Jordan Funeral Service,Inc. 4001 Benning Rd.,N.E.(Wash.,D.C.20019)

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Metastatic Bladder Cancer — 6 mos

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evellable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer**: On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Jay Alan Ocuin, MD.
29c. License number: DO021955
29d. Dete signed *(Month, Dey, Yeer)*: 12/23/01

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Jay Alan Ocuin,M.D. 106 Irving St.,N.W. Suite 418 (Wash.,D.C.) 20010

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 26 2001
32. Registrer's Signeture: Barbara B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(4)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42961

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evart Ford Warren

2. Date of Death Month Day Year: December 26, 2001

3. Time of Death: 11:40P M

4a. Facility Name *(If not institution, give street and number)*: Heron Point Nursing Facility

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 225-52-6542

6. Sex: 1☐M 2☐F — X

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 1, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 205 Heron Point

10f. Zip Code: 21620

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yas, Giva Yaar or Dates: WWII

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Optomitrist

16b. Kind of Businass/Industry: Medical

17. Father's Nama *(First, Middle, Last)*: George Townsley Warren

18. Mothar's Name *(First, Middle, Maiden Surname)*: Fannie S. Ford

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth A. Warren/ wife

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 205 Heron Point Chestertown, Md. 21620

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Cremation Cntr. — Date: 12/28

20c. Location - City or Town, State: Stevensville, MD

21. Signature of Funeral Service Licensee: Burt J. Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein, Newnam Funeral Home PA 130 Speer Rd. Chestertown, Md. 21620 778-0055

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on eech line.

Immediata Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT — Approximate Interval Between Onset and Death: 10 HRS

Dua to (or as a consequence of):

b. HYPERTENSION — 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown

23d. Data of dalivery: Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobacco usa contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Ware autopsy findings availabla prior to compiation of causa of death? 1☐Yas 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledga, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John C. Seymour

29c. Licansa number: D-0013824

29d. Date signed *(Month, Day, Year)*: 12-27-01

30. Nama and address of person who completed causa of daath (Item 23a) (Typa, Print): Dr. John C. Seymour 122 Speer Road Suite 5 Chestertown, Md. 21620

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 2002

32. Registrar's Signature: Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42962

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fannie F. Wilson

2. Date of Death (Month, Day, Year): Dec. 23, 2001

3. Time of Death: 6;30 AM

4a. Facility Name (If not institution, give street and number): Chestertown Nursing &Rehab.

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 215-38-0140

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 26, 1910

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 212 Calvert Street

10f. Zip Code: 21620

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Educator

17. Father's Name (First, Middle, Last): Charles Frisby

18. Mother's Name (First, Middle, Meiden Surname): Rebecca Goldsborough

19a. Informant's Name/Relationship (Type, Print): Mrs. Joan Barnett (Neice)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box St. Michael, Md. 21663

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Janes U.M. Cem.

Date: 12-29-01

20c. Location - City or Town, State: Chestertown, Md.

21. Signeture of Funeral Service Licensee: ▶ Harry M. Reese M00482

22. Name and Address of Facility: Walley Funeral Service - Chestertown MD 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Arterio Sclerotic Cardio Vascular Disease — >15 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN / Hx SVT / CAD 3 / Arthritis / Anemia

Hypomagnesemia

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residenca 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Neil Stoddard

29c. License number: D50996

29d. Date signed (Month, Day, Year): 12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neil Stoddard M.D. 100 Brown St. Chestertown, Md. 21620

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001

32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42963

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elmer S. Welsh
2. Date of Death: Month Dec. Day 21 Year 2001
3. Time of Death: 10:57P^M
4a. Facility Name (If not institution, give street and number): 16809 Old Field Lane
4b. City, Town, or Location of Death: Hughesville
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579-10-2979
6. Sex: 1 ☒M 2 ☐F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 12 1912
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: VA
10b. County: Fauquier
10c. City, Town or Location: Summerduck
10d. Inside City Limits: 1 ☐Yes 2 ☒No
10e. Street and Number: 14487 Snake Castle Road
10f. Zip Code: 22742
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐Never Married 2 ☐Married ☒Widowed 4 ☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒Yes 2 ☐No If Yes, Give Year or Dates: Army Reserve
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 ☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Master Electrician
18b. Kind of Business/Industry: Federal Gov't
17. Father's Name (First, Middle, Last): Charles D. Welsh
18. Mother's Name (First, Middle, Maiden Surname): Margaret R. Crawford
19a. Informant's Name/Relationship (Type, Print): Charles E. Welsh (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16809 Old Field Ln. Hughesville, MD 20637
20a. Method of Disposition: 1 ☒Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery 2001
Date: Dec 28
20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: Gary J. Goff
22. Name and Address of Facility: Lee Funeral Home Calvert, PA 8125 Southern MD Blvd. Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Prostate Cancer — Approximate Interval Between Onset and Death: More than 6 months.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐No 9 ☐Unknown
23c. If yes, outcome of pregnancy: 1 ☐Live birth 2 ☐Fetal death 3 ☐Ectopic pregnancy 4 ☐Pregnant at time of death 5 ☐Other (specify) 9 ☐Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Paroxysmal Atrial fibrillation.

23e. Did tobacco use contribute to the cause of death? 1 ☐Yes 2 ☐No 3 ☐Probably 4 ☑Unknown
24a. Was an autopsy performed? 1 ☐Yes 2 ☑No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐Yes 2 ☑No
28. Place of Death (Check only one): Hospital: 1 ☐Inpatient 2 ☐ER/Outpatient 3 ☐DOA; Other: 4 ☐Nursing Home 5 ☑Residence 6 ☐Other (Specify)
27. Manner of Death: 1 ☑Natural 2 ☐Accident 3 ☐Suicide 4 ☐Homicide 5 ☐Pending investigation 6 ☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐Yes 2 ☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gyan. C. Surana
29c. License number: D 50653
29d. Date signed (Month, Day, Year): 12-24-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GYAN. C. SURANA 5851- Dealechurchton Road Deale MD 20751

State Registrar

31. Date filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signature: Geneva B Sparks

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DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42964

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Augusta McCeney Young	December 23, 2001	1:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Rehab. and Nursing Center	Burtonsville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-38-2285	1☐ M 2☒ F	95 Yrs.			Feb 20, 1906	Maryland

Usuet Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14000 Castle Boulevard, Apt 711	20904	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	School Teacher	Education

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
William H. McCeney	Anna Barnitz

19e. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert S. McCeney, Jr./ Nephew	402 Burnt Mills Avenue, Silver Spring, MD 20901

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Buriat 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	St. Mark's Episcopal Cemetery	Dec 28 2001	Silver Spring, MD

21. Signeture of Funeral Service Licensee: James E. Dailey

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Chronic Renal Failure	years
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	Due to (or as e consequence of): b. Hypertension	years
	Due to (or as e consequence of): c.	
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnency 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown	23d. Dete of delivery Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Osteoarthritis

Chronic Venous Insufficiency

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es steted.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
Robert J. Ginsberg MD	D 25344	December 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert J. Ginsberg, MD 2415 Musgrove Road #209, Silver Spring, MD 20904

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(8)

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
DEC 28 2001	Teresa G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42965

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILSON MARION ARDIS
2. Date of Death (Month, Day, Year): DEC. 21, 2001
3. Time of Death: 1:35 AM
4a. Facility Name (If not institution, give street and number): Salisbury Rehab & Nursing Center
4b. City, Town, or Location of Death: Salisbury, Md.
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 217-16-9001
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/2/1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Pocomoke City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 302 Market Street
10f. Zip Code: 21851
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown
16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Marion Lee Ardis
18. Mother's Name (First, Middle, Maiden Surname): Ada Payne

19a. Informant's Name/Relationship (Type, Print): Ralph Ardis/ Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 705 Second Street, Pocomoke, MD 21851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Remson Cemetery
Date: 12/24/01
20c. Location - City or Town, State: Pocomoke, MD

21. Signature of Funeral Service Licensee: Michael A Dean MO1129
22. Name and Address of Facility: Holloway Melson Funeral Home. P.A. 103 Linden Ave. Pocomoke, MD 21851

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of): b. Heart failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D-29349
29d. Date signed (Month, Day, Year): 12/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WILSON MARION ARDIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42966

August Bokich Alavanja

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
AUGUST BAKOTICH ALAVANJA	December, 28 2001	6:58P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Civista Medical Center	La Plata	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
065-18-6440	1☒M 2☐F	87 Yrs.			DEC.3,1914	YUGOSLAVIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
VIRGINIA	AUGUSTA	STAUNTON	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
2408 SPRINGHILL ROAD	24401	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Rece - Americen Indien, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
UNKNOWN		UNION PAINTER	PAINTING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
TOMA BAKOTIC ALAVANJA	MATIJA STRIHIC

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GOLDIE ALAVANJA-SPOUSE	2408 SPRINGHILL RD. STAUNTON, VIRGINIA24401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	STONEWALL JACKSON CEM.	1-2-02	LEXINGTON, VIRGINIA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M00479 Michael O. Raymond	RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646

Physician /Medical Examiner — **Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ischemic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d. Due to (or as e consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and menner as steted.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
Yahia M. Tagouri MD	D-50883	Dec. 30. 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yahia Tagouri, MD 25500 Point Lookout Rd. Leonardtown, MD. 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 02 2002	Penny G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Amend Item#26 Per Phy 12/28/2001 HCHD LM

Reg. No. 2001 42967

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Carmelina Mary Anuszewski	December 23, 2001	12:30A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12947 Harford Road	Hydes	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-12-5824	1☐M 2☒F	78 Yrs.			May 28, 1923	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6023 Mannington Avenue	21206	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade		Sales Clerk	Retail

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Gattuso	Vincezina DiTrapani

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Patricia Mooney (daughter)	12947 Harford Rd., Hydes, MD 21082

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Gardens of Faith Cem.	12/28/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Carol Bumbera	Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Interstitial Pulmonary Fibrosis	weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Diabetes Mellitis	months
	Due to (or as a consequence of): c. Renal Insufficiency	months
	Due to (or as a consequence of): d. Hyperlipidemia	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) Daughter's Residence

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Roy E Cameron	D20073	12-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Lowe 7672 Belair Rd Baltimore, MD 21236

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Denise G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 26e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42968

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Stanley Banks

2. Date of Death Month Day Year: December 26, 2001

3. Time of Death: 10:05PM M

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-22-6194

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 20, 1929

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Parsonsburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 31912 Pembroke Court

10f. Zip Code: 21849

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): ---

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Office Supply

17. Father's Name (First, Middle, Last): Stanford Lewis Banks

18. Mother's Name (First, Middle, Maiden Surname): Pearl Virginia Williams

19a. Informant's Name/Reletionship (Type, Print): Doris B. Banks - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31912 Pembroke Court, Parsonsburg, MD 21849

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Shad Point Cemetery

Date: 12/29/2001

20c. Location - City or Town, State: Salisbury, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Holloway Funeral Home, Professional Association 501 Snow Hill Road, Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. Metastatic Lung Cancer — Due to (or as e consequence of): — month

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or es e consequence of):

c. — Due to (or as a consequence of):

d. —

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probebly 4 [ ] Unknown

24e. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Death 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2 [ ] Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and menner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D29105

29d. Date signed (Month, Dey, Yeer): 12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christjon Huddleston, 106 Milford Street, Salisbury, MD 21804

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 2 8 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

BANKS, RICHARD #213-22-6194 12/26/01 2405 72y0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42969

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
ANNA	NIELSEN	BRADFIELD	December 20, 2001	1:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SNOW HILL NURSING HOME	SNOW HILL	WORCESTER

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
048-09-3859	1☐ M 2☒ F	83 Yrs.			August 6, 1918	Connecticut

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
300 Lemmon Hill Lane	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	-	Clerical	Insurance

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Peter Christian Nielsen	Karen Marie Swendsen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara B. Dittrich/Daughter	105 W. Market St., Snow Hill, MD 21863

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Salisbury Crematory	12/22/01	Salisbury, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finet disease or condition resulting in death)	a. Acute CVA	28 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Arteriosclerotic Cerebrovascular Disease	10 yrs.
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Myelogenous Leukemia. Thrombocytosis. Coronary Artery Disease Essential Hypertension. Dementia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gregorio M. Belloso M.D.	D29505	12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregorio M. Belloso, M.D. 5302 Chinaberry Dr., Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 22 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DQ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42970

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Edward R. Brown, Sr.	December 22 2001	1203 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
010-20-9052	1 ☒ M 2 ☐ F	75 Yrs.			March 27, 1926	NY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Wicomico	Salisbury	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
536 Village Court	21801	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Navy	1 ☐ Yes 2 ☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown		Roofer	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Raymond Edward Brown	Minerva Hutchinson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward Brown, Jr./son	113 Lena Beth Dr., Leesville, LA 71446

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Salisbury Crematory		Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CAVERNOUS SINUS THROMBOSIS WITH	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): VENOUS INFARCT.	8 Days
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown	1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mahesh Moondra MD	D32014	12/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MAHESH MOONDRA MD 106 MILFORD ST SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	Denise G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

010-20-9052

Edward Brown

2 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42971

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Monta Bonner
2. Date of Death — Month: December, Day: 22, Year: 2001
3. Time of Death: 2210
4e. Facility Name *(If not Institution, give street and number)*: Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-12-8635
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 1, 1928
9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3901 Darleigh Road, Condo 1E
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Assistant
16b. Kind of Business/Industry: Defense
17. Father's Name *(First, Middle, Last)*: Thomas Carolan
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Moran
19e. Informant's Name/Relationship *(Type, Print)*: Mr. Hoyt V. Bonner (husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3901 Darleigh Rd., Condo 1E, Baltimore, MD 21236
20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Garrison Forest VA Cem.
Date: 12/28/01
20c. Location - City or Town, State: Owings Mills, MD
21. Signature of Funeral Service Licensee: ▶ Robert T. Boyer
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung cancer	6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sydney Dy PHYSICIAN
29c. License number: D53590
29d. Date signed *(Month, Day, Year)*: DECEMBER 23, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SYDNEY DY, MD DIVISION OF GENERAL INTERNAL MEDICINE 1830 BUILDING, 8th FLOOR, 1830 EAST MONUMENT, BALTIMORE MD 21205

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 28 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12/22/01 @ 22:10 P.M.
Bonner, Maryann
15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42972

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
NELLIE	RUTH	BELL	December 22 2001	4:20 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Wicomico Nursing Home	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-10-9941	1☐ M 2☒ F	88 Yrs.			August 10, 1913	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
900 Booth Street	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	-	Folder/Presser	Manhattan Shirt Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James H. Clough	Nancy Myrtle Sparks

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty Lee Robbins/Daughter	8914 Woodcreek Pkwy, Delmar, MD 21875

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Wicomico Memorial Park	12/26/01	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Keith R Mumey CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EDEMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTNE HEART FAILURE.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES, HYPERTENSION, CEREBRO VASCULAR ACCIDENT.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D0057709	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanjay Bangarulingam MD 614EasternSHore Drive Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 42973

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD DAWSON CRAFT
2. Data of Death Month / Day / Yaar: DEC 20, 2001
3. Tima of Daath: 07:00 AM
4a. Facility Nama *(If not institution, give street and number)*: 22 UPPER CHESAPEAKE MED CTR
4b. City, Town, or Location of Daath: BELAIR
4c. County of Death: HARFORD

Funeral Director

5. Social Security Numbar: 220-14-9338
6. Sax: 1 [X] M 2 [ ] F
7. Aga *(In yrs. last birthday)*: 77 Yrs.
If Undar 1 Year: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yeer)*: July 1, 1924
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. Stata: Md.
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Insida City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2701 Greenspring Avenue West
10f. Zip Code: 21085
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No. If Yas, Give Year or Datas: 1943 to 1946
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* white

15. Decedant's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12 years; Collaga (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: self-employed
16b. Kind of Businass/Industry: fabric

17. Fathar's Nama *(First, Middle, Last)*: Dawson Craft
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Mildred Nelson

19a. Informant's Name/Ralationship *(Type, Print)*: Marianne Craft/wife
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2701 Greenspring Avenue West, Joppa, Md. 21085

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory
Data: 12/22/01
20c. Location - City or Town, Stata: Baltimore, Md.

21. Signature of Funaral Service Licensaa: Amanda Davis
22. Nama and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 West MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Intarval Batwaan Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in daath)
a. ASCVD

Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last
b. Dua to (or as a consequance of):
c. Due to (or es a consequance of):
d. Dua to (or as e consequance of):

IF FEMALE:
23b. Was decedent pregnant in tha past 12 months? 1 [ ] Yas 2 [ ] No 9 [ ] Unknown
23c. If yas, outcoma of pragnancy: 1 [ ] Liva birth 2 [ ] Fatal daath 3 [ ] Ectopic pregnancy 4 [ ] Pragnant at tima of daath 5 [ ] Othar *(specify)* 9 [ ] Unknown
23d. Data of dalivary Month / Day / Year

Part II. **Othar significant conditions** contributing to daath but not resulting in the undarlying causa givan in Part I.
S/P CORONARY ARTERY BYPASS
COPD
ASBESTOSIS

23a. Did tobacco usa contributa to tha causa of daath? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings availabla prior to compilation of causa of daath? 1 [ ] Yas 2 [ ] No
25. Was cesa refarred to medical examinar? 1 [X] Yas 2 [ ] No
26. Placa of Daath *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Othar *(Specify)*
27. Mannar of Daath: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not ba datarminad
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurrad
26a. Placa of Injury - At homa, farm, streat, fectory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1 [ ] **Certifying Physician:** To tha bast of my knowledga, daath occurrad at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2 [X] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.
29b. Signatura and titla of certifiar: DME
29c. Licensa number: OCME
29d. Data signad *(Month, Dey, Year)*: DEC 20, 2001
30. Nama and addrass of person who complatad causa of daath (Itam 23a) (Typa, Print): GS PRABHU MD 728 BELAIR RD #134 BELAIR MD 21014.

State Registrar

31. Date filad *(Month, Dey, Yeer)*: DEC 21 2001
32. Registrar's Signature: Geneva B Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

jm

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42974

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RONALD RICHARD DeCLARK
2. Date of Death (Month, Day, Year): Dec. 29, 2001
3. Time of Death: 16:06
4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 539 22 5229
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 26, 1930
9. Birthplace *(State or Foreign Country)*: Idaho

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 332 William Street
10f. Zip Code: 21811
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 ☒ Yes 2 ☐ No — If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Servant
16b. Kind of Business/Industry: United States Dept. of Agriculture

17. Father's Name *(First, Middle, Last)*: David Joseph DeClark
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Burnsen

19a. Informant's Name/Relationship *(Type, Print)*: David Lee DeClark
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7210 Galgate Dr. Springfield, VA 22153

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cape Henlopen Crematory — Date: 12/31/01
20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: W. Fred Burbage
22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in deeth)
a. PNEUMONIA — 1 day

Due to (or es a consequenca of):
b. Chronic obstructive pulmonary Disease — 4 years

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last
Due to (or es e consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Piece of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and pleca, end due to the cause(s) and manner steted.
29b. Signature and title of certifier: MD
29c. License number: D0047676
29d. Date signed *(Month, Day, Year)*: 12/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BSHAR TOULEIMAT 9933 Healthway Dr Berlin MD 21811

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 31 2001
32. Registrer's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Ronald DeClark 539-22-5229

DoB 1/26/30 DoD 12/29/01

ET 1411

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42975

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George Hines Dryden, Sr.

2. Date of Death Month Day Year: December 27, 2001

3. Time of Death: 0944 M

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-36-1068

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 20, 1920

9. Birthplace *(State or Foreign Country)*: MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Newark

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 8064 Queponco Rd.

10f. Zip Code: 21841

10g. Citizen of What Country?: US

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

18b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: Claude S. Dryden

18. Mother's Name *(First, Middle, Meiden Surname)*: Marlie Hastings

19a. Intormant's Name/Relationship *(Type, Print)*: Edith A. Dryden

19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8064 Queponco Rd., Newark, Md. 21841

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Bates Cemetery

Date: 12-30-01

20c. Location - City or Town, Stete: Snow Hill, Md.

21. Signature of Funeral Service Licensee: W. Eric Burbage

22. Name and Address of Facility: The Burbage Funeral Home, 208 West Federal St., Snow Hill, Md. 21863

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): a. Congestive heart failure

Due to (or as e consequence of): b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as e consequence of): c.

Due to (or as e consequence of): d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent et time of deeth 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause ot death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D55658

29d. Dete signed *(Month, Day, Year)*: 12/27/2001

30. Name and address ot person who completed cause ot death (Item 23a) (Type, Print): Frank Arena MD. 400 Eastern Shore Dr. Salisbury MD.

State Registrar

31. Date tiled *(Month, Dey, Year)*: DEC 3 1 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

George Dryden 217-36-1068

ET 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42976

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM PATRICK DAVIS III
2. Date of Death: Month 12 Day 20 Year 2001
3. Time of Death: 0700
4e. Facility Name (If not institution, give street and number): 7 GOLDEN EYE CT.
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 219-22-8979
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-9-27
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: BERLIN
10d. Inside City Limits: [ ] Yes [X] No
10e. Street and Number: 7 GOLDEN EYE CT.
10f. Zip Code: 21811
10g. Citizen of What Country? U.S.A.

11. Marital Status: [ ] Never Married [X] Married [ ] Widowed [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): [ ] Yes [X] No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSULTANT
16b. Kind of Business/Industry: INSURANCE

17. Father's Name (First, Middle, Last): WILLIAM PARTICK DAVIS, JR.
18. Mother's Name (First, Middle, Maiden Surname): MARGARRETTA MARTIN

19a. Informant's Name/Relationship (Type, Print): MARGARET W. DAVIS SPOUSE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 GOLDEN EYE CT., OCEAN PINES, MD, 21811

20e. Method of Disposition: [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SALISBURY CREMATORY
Date: 12-21
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Mitral regurgitation, Congestive heart failure

23b. Did tobacco use contribute to the cause of death? [ ] Yes [ ] No [ ] Probably [X] Unknown

24a. Was an autopsy performed? [ ] Yes [X] No
24b. Were autopsy findings available prior to completion of cause of death? [ ] Yes [ ] No

25. Was case referred to medical examiner? [ ] Yes [X] No

26. Place of Death (Check only one): Hospital: [ ] Inpatient [ ] ER/Outpatient [ ] DOA — Other: [ ] Nursing Home [X] Residence [ ] Other (Specify)

27. Manner of Death: [X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending investigation [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? [ ] Yes [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jack VanVoorhees MD
29c. License number: D0055906
29d. Date signed (Month, Day, Year): 12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK VANVOORHEES 314 Franklin Ave. Suite 402, Berlin, MD 21811

EPL 1041

State Registrar

31. Date filed (Month, Day, Year): DEC 21 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42977

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE MADELINE DYSON

2. Date of Death (Month, Day, Year): DECEMBER 31, 2001

3. Time of Death: 10:41 AM

4a. Facility Name *(If not institution, give street and number)*: 6F HAMPTON COURT

4b. City, Town, or Location of Death: BRYANS ROAD

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 578-44-6116

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC. 4, 1918

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedant

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: BRYANS ROAD

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6F HAMPTON COURT

10f. Zip Code: 20616

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: PRIVATE

17. Father's Name *(First, Middle, Last)*: ROBERT BARNES

18. Mother's Name *(First, Middle, Maiden Surname)*: MAMMIE KELTON

19a. Informent's Name/Relationship *(Type, Print)*: SHIRLEY HAWKINS / DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3425 STUMPNECK ROAD, INDIAN HEAD, MARYLAND 20640

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: ST. CHARLES CEMETERY

Data: 1/7/2002

20c. Location - City or Town, State: GLYMONT, MARYLAND

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson

LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications thet caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert teilure. List only one ceuse on each tine. — Approximate Interval Between Onset end Death

Immediete Cause (Final disaasa or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

HYPERTENSION

AORTIL ANEURYSM

HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinton, death occurred at the time, date and ptace, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Elliott Perlin

29c. Licansa number: D-08674

29d. Data signed *(Month, Day, Year)*: JANUARY 2, 2002

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): ELLIOTT PERLIN, M.D. - 6510 KENILWORTH AVENUE, #2800, RIVERDALE, MARYLAND 20737

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 03 2002

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar: Amend Item#23a Per Phy 12/21/2001 HCHD LM

Reg. No. 2001 42978

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Grace DeVoto	December 16, 2001	11:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3515 Fallston Road	Fallston	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-07-9548	1☐ M 2☒ F	87 Yrs.			April 27, 1914	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Harford	Fallston	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3515 Fallston Road	21047	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th grade		seamstress	clothier

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Gelmini	Jennie Cinquegrani

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Mary Beverly Blum/daughter	3515 Fallston Road, Fallston, Md. 21047

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Highview Mem. Gdns.	12/20/01	Fallston, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian A. Wellen	Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Chronic Renal Failure	Years
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. ~~Kidney Failure~~ Kidney Disease	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings availeble prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case relerred to medical exeminer?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28l. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ _____, M.D.	D0047813	December 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BASHAR KARA KASH 520 Upper Chesapeake Dr. Suite 211 Bel Air MD 21014

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
DEC 21 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturet', or items 28e or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42979

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hilda Smith Davis

2. Date of Death: Month Dec. Day 31, Year 2001

3. Time of Death: 10:35 AM

4a. Facility Name (If not institution, give street and number): Salisbury Rehab & Nursing Center

4b. City, Town, or Location of Death: Salisbury, Md.

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 220-28-2627

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 24, 1931

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: md | 10b. County: Worcester | 10c. City, Town or Location: Berlin | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10522 Assateague Rd. | 10f. Zip Code: 21811 | 10g. Citizen of What Country? US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Smith

18. Mother's Name (First, Middle, Maiden Surname): Daisey Massey

19a. Informant's Name/Relationship (Type, Print): Franklin L. Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10522 Assateague Rd., Berlin, Md. 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Cemetery | Date: 1-4-2002 | 20c. Location - City or Town, State: Berlin, Md.

21. Signature of Funeral Service Licensee: W. Rick Burbage

22. Name and Address of Facility: The Burbage Funeral Home, 108 William St., Berlin, Md. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive heart failure	years
Due to (or as a consequence of):	b. Heart failure	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Diabetes	years
Due to (or as a consequence of):	d. Heart	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 025349

29d. Date signed (Month, Day, Year): 12/31/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 02 2002

32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

DAVIS, HILDA SMITH

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42980

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pasquale Falzarano
2. Date of Death: Month 12 Day 27 Year 2001
3. Time of Death: 13:02
4a. Facility Name (If not institution, give street and number): Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 142 22 7614
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 19, 1932
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 23 Fosse Grange
10f. Zip Coda: 21811
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Joseph Falzarano
18. Mother's Name (First, Middle, Maiden Surname): Angela Maria Falzarano

19a. Informant's Name/Relationship (Type, Print): Josephine F. Falzarano
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 Fosse Grange Berlin, MD 21811

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cape Henlopen Crematory
Data: 12/31/01
20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: W. Kirk Burbage
22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MI
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HTN
hypercholesterolemia
BPH

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D.O.
29c. License number: H44828
29d. Date signed (Month, Day, Year): 12/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brookellen Rider 9733 Healtway Dr. Berlin, MD 21811

State Registrar

31. Date filed (Month, Day, Year): DEC 31 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Falzarano, Pasquale 69 M W
142227614 2/19/32 12/27/01 21302

ET 10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42981

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Florence Elizabeth Frame

2. Date of Death Month Dey Yaer: DECEMBER 26 2001

3. Time of Death: 1319 M

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Deeth: WICOMICO

Funeral Director

5. Social Security Number: 047-20-8138

6. Sex: 1☐ M 2☒F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Aug.24,1920

9. Birthplece (Stete or Foreign Country): MD

Usuel Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 807 Boardwalk

10f. Zip Code: 21842

10g. Citizen of What Country?: US

11. Maritel Status: 1☐ Naver Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner-Operator

16b. Kind of Businass/Industry: Hotel

17. Father's Neme (First, Middle, Last): Robert Guy Ayres

18. Mother's Neme (First, Middle, Maiden Surname): Virginia Lee Whaley

19a. Informant's Name/Reletionship (Type, Print): Susan Whaley Frame Pilchard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3903 Hillandale Ct., N.W., Washington, D.C. 20007

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Cape Henlopen Crematory

Dete: 12-27-01

20c. Location - City or Town, Stete: Frankford, Delaware

21. Signature of Funeral Service Licensee: Kirk Burbage M00701

22. Name and Address of Facility: The Burbage Funeral Home 108 William St., Berlin, Md. 21811

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each lina.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth): a. RECURRENT PULMONARY EMBOLUS — 24 HRS

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnent in the pest 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Dete of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

R (W) MASS POSSIBLE CANCER

23e. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes casa refarrad to medical axeminer? 1☐ Yes 2☒ No

28. Place of Daeth (Check only ona)

Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner es steted.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: D J Yurkewicz

29c. License number: D20912

29d. Dete signed (Month, Dey, Yeer): 12-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DENNIS CHODNICKI, M.D. 400 E. SHORE DR SALISBURY, MD

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 27 2001

32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

8/24/20 13:19

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

047-20-8138 Florence Frame

ET 10

01-7302-045
Alan Fleming
TLC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42982

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alan Dale Fleming
2. Date of Death Month / Day / Year: December 24, 2001
3. Time of Death: 22:20 p.m.
4a. Facility Name *(If not institution, give street and number)*: Peninsula Regional Medical Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 216-64-8526
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 1,1955
9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 623 Priscilla Street
10f. Zip Code: 21801
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter
16b. Kind of Business/Industry: Contractor

17. Father's Name *(First, Middle, Last)*: Dalton Dickerson Fleming
18. Mother's Name *(First, Middle, Maiden Surname)*: Martha Evelyn Welty

19a. Informant's Name/Relationship *(Type, Print)*: Marie L. Fleming
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1542 Snow Hill Rd., Stockton, Md. 21864

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Stockton Memory Gardens — Date: 12-28-01
20c. Location - City or Town, State: Stockton, Md.

21. Signature of Funeral Service Licensee: W. Fitz Burbage
22. Name and Address of Facility: The Burbage Funeral Home, 108 William St., Berlin, Md. 21811

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. VENA PYURIA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ALCOHOLISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: 12-24-01
28b. Time of Injury: 21:42 P M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: SUBJECT FELL DOWN THE STAIRS
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: AT HOME
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 623 PRISCILLA ST SALISBURY WICOMICO MD

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Marjorie Mc Shane M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: December 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M DEYSACH A. KOBER MD — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #26, 12/26/2001, C.M, Wchd

Certificate of Death

Reg. No. 2001 42983

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
LEWIS	A.	FREY	12	24	2001	1735

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1 MEADOW ST.	BERLIN	WORCESTER

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
190-05-8430	1☒M 2☐F	93 Yrs.					6-22-08	PA.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	WORCESTER	BERLIN	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1 MEADOW ST.	21811	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		LABORER	GLASS FACTORY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
OSCAR FREY	ANNA WEAST

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LEWIS FREY	7 OCEANS END BERLIN, MD. 21811

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	TWIN VALLEY MEM. PK.	12-29	BELMONT, PA.

21. Signature of Funeral Service Licensee ▶ John A. Ullrich

22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Carcinoma	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Joseph B Mezzetti DO	H57178	12/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CM 6 19514 Racetrack Rd, Unit C, Berlin, MD 21811

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 26 2001	▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42984

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Anneliese Frey	December 18 2001	11:05 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Citizens Nursing Home	Havre DeGrace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
135-30-1841	1 ☐ M 2 ☒ F	87 Yrs.					05/18/1914	Germany

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Havre de Grace	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
67 Robinhood Rd.	21078	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1 year	Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gustaf Thomaier	Elise Faus

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Wolfdieter E. Frey- Son	14 Marquis Dr., Gaithersburg, MD 20878

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	R.A. Ferris & Co.	12/20/01	West Chester, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Elaine M. Smith	Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Dehydration	3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Alzheimer's Dementia	5 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure
Chronic obstructive pulmonary disease
Dysphagia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Prashant Shukla	D0004805O	12/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Prashant Shukla, MD 319 South Union Avenue Havre de Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 2001	▶ Jenna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

dm

Frey, Anneliese

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 42985

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HENRY T. FORD	Dec. 18, 2001	10:15A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Center	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
160-16-8597	1 ☐ M 2 ☐ F XX	86 Yrs.			Aug. 7, 1915	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Whiteford	1 ☐ Yes 2 ☐ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2135 Whiteford Road	21160	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married XX 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW2	1 ☐ Yes 2 ☒ No XX Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		civilian Gunner	Civil Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bryan P. Ford	Mary Hughes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Annie D. Ford- wife	2135 Whiteford Rd., Whiteford, MD 21160

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial XX 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Slate Ridge Cemetery	12/21/01	Delta, PA

21. Signature of Funeral Service Licensee ▶ Jeffrey P. Lawlis

22. Name and Address of Facility: Harkins F.H.Inc., 600 Main St., Delta, PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstructive pulmonary disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Myocardial infarction	
	Due to (or as a consequence of): c. Respiratory failure	
	Due to (or as a consequence of): d. Ventricular tachycardia	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D45921	December 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED F. MAHMOOD 4-B North Avenue Suite 302 Bel Air Maryland 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Ford, Henry

LM

5+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42986

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aileen Fortner

2. Date of Death Month / Day / Year: December 22, 2001

3. Time of Death: 09:57 am

4a. Facility Name *(If not institution, give street and number)*: The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 219-22-7188

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 3, 1926

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Churchville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 516 Priestford Road

10f. Zip Code: 21028

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: In home

17. Father's Name *(First, Middle, Last)*: Joseph Jennings

18. Mother's Name *(First, Middle, Maiden Surname)*: Ada Boyles

19a. Interment's Name/Relationship *(Type, Print)*: Mrs. Sharon Hess (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 32 Sarah Drive Elkton, MD 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harford Memorial Gardens

Date: 12/27/01

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. cardiomyopathy — ten years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dee Walker Ford, M.D.

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: December 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dee Walker Ford, 110 Tower Building, Johns Hopkins Hospital, Baltimore, MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CAJ

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42987

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Francis Glinowiecki, Jr.

2. Date of Death (Month, Day, Year): December 24, 2001

3. Time of Death: 10:00 AM

4a. Facility Name (If not institution, give street and number): 9203 Mediterranean Drive

4b. City, Town, or Location of Death: Ocean City

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 216-30-1043

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 30, 1935

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9203 Mediterranean Drive

10f. Zip Code: 21842

10g. Citizen of What Country?: US

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Longshoreman

16b. Kind of Business/Industry: Shipyard

17. Father's Name (First, Middle, Last): Walter Francis Glinowiecki, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Victoria Lornez

19a. Informant's Name/Relationship (Type, Print): Walter J. Glinowiecki

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4008 Alberta Ave., Pasadena, Md. 21122

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomy Board of Md.

Date: 12-24-01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Mark Burbage 1/10/01

22. Name and Address of Facility: The Burbage Funeral Home, 108 William St., Berlin, Md. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ASCVD — several yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dorothy C. Holzworth, M.D.

29c. License number: D 06241

29d. Date signed (Month, Day, Year): 12-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dorothy C. Holzworth M.D. 203 Snow St. Snow Hill, Md. 21863

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Geneva G. Sparks

CM 6

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPM
01-7357-035
UNK. 01-363
FLORINA TOMAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42988

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Florinda Tomas Gabriel
2. Date of Death (Month, Day, Year): DECEMBER 29, 2001
3. Time of Death: 15:52
4a. Facility Name (If not institution, give street and number): MARYLAND RTE. 302 ¼ MILE EAST OF RTE. 313
4b. City, Town, or Location of Death: BARCLAY
4c. County of Death: QUEEN ANNE'S

Funeral Director

5. Social Security Number: no
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 24 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 1, 1977
9. Birthplace (State or Foreign Country): Guatemala

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne
10c. City, Town or Location: Queenstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 390 Main Street
10f. Zip Code: 21658
10g. Citizen of What Country?: Guatemala

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No Specify: Guatemala
14. Race - American Indian, Black, White, etc. Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 1 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unemployed
16b. Kind of Business/Industry: unemployed

17. Father's Name (First, Middle, Last): Francisco Tomas Aguilar
18. Mother's Name (First, Middle, Maiden Surname): Petrona Gabriel Perez

19a. Informant's Name/Relationship (Type, Print): Silvia Morales/ friend x
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 394 Marydel, MD 21649

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Guatemala — Date: unknown
20c. Location - City or Town, State: Guatemala

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Fleegle & Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 12-29-01
28b. Time of Injury: 14:46 P M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: PASSENGER IN MOTORVEHICLE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY
28f. Location (Street and Number or Rural Route Number, City or Town, State): MD 302 ¼ MILE EAST OF MD 313 QUEEN ANNE'S MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wayne Mechell
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANNE A. KOREN MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN - 2 2002
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42989

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE W. HUDSON
2. Date of Death (Month, Day, Year): DECEMBER 15, 2001
3. Time of Death: 1:52 A.M.
4a. Facility Name (If not institution, give street and number): BERLIN NURSING HOME
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 218-48-6859
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 6-3-1919
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WORCESTER
10c. City, Town or Location: BISHOPVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10737 ST.MARTIN'S NECK ROAD
10f. Zip Code: 21813
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): HARRY T. WATSON
18. Mother's Name (First, Middle, Malden Surname): MAE TAYLOR

19a. Informant's Name/Relationship (Type, Print): GLORIA W. GUM/ SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32 MAIN ST., P.O. BOX 68, FRANKFORD, DE. 19945

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): BISHOPVILLE CEMETERY
Date: 12-18-01
20c. Location - City or Town, State: BISHOPVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Odessa L. Nelson
22. Name and Address of Facility: MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disaase or condition resulting in death)	a. Non-Small Cell Carcinoma of Lung	4 mos.
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malignant Pleural Effusion; Senile Dementia; Chronic Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier: Gregorio M Belloso Md
29c. Licansa number: D 29505
29d. Data signed (Month, Dey, Year): 12-18-2001

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR. SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): DEC 2 0 2001
32. Registrar's Signeture: G. Sparks

CM 2

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42990

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUSSELL HIRSCHAUER, SR.

2. Date of Death (Month, Day, Year): Dec. 27, 2001

3. Time of Death: 2:25 A.M.

4a. Facility Name *(If not institution, give street and number)*: Berlin Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 217 07 1054

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 22, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 7405 Yacht Club Dr.

10f. Zip Code: 21811

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Dacedent Evar in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Aeronautical Engineer

16b. Kind of Business/Industry: Space Exploration

17. Father's Name *(First, Middle, Last)*: Andrew Lewis Hirschauer

18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine M. Behling

19a. Informant's Name/Relationship *(Type, Print)*: James Willam Hirschauer

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12109 Sugar Hill Ct. Bishopville, MD 21813

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cape Henlopen Crematory

Date: 12/27/01

20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: W. Reid Burbage

22. Name and Address of Facility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Metastatic Prostatic Cancer

Due to (or as a consequence of):

b. Prostatic Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

Sepsis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, factory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D48221

29d. Data signad *(Month, Day, Year)*: December 27 01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): ET 6 Julio M. DePena, 18 mason Dixn Shp Otr Selbyville DE

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 2 8 2001

32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42991

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
FRED	B.	HUBBERT	DECEMBER 27 2001	2347 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-20-4912	1☒M 2☐F	74 Yrs.			JUNE 26, 1927	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
118 HOLLAND AVE.	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII KOREA	1☐Yes 2☒No Specify: A	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	POSTAL CARRIER	U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ALVIN CLARK HUBBERT, SR.	MARY BURGGRAF

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JEAN B. HUBBERT - WIFE	118 HOLLAND AVE. SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CREMATORY OF DELMARVA	12/28/01	DELMAR, DELAWARE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ B. Kurt Phynn, CFSP	BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest ! V. Fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Acute myo. infarction.
Due to (or as a consequence of):
c. Coronary Atherosclerosis.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
a. Hypertension.
Parkinsons disease.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D 25036.	12/28/01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D. H. R. HEDA. 614 D Eastern Shore Drive · SALISBURY MD.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12/27/01 23:47

Fred Hubbert 215-20-4912

5 MP 1 VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 42992

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
MARTIN	NICHOLAS	HUEBSCHMAN	DECEMBER 24 2001	1105 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
705-09-0509	1☒M 2☐F	95 Yrs.			12-18-1906	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4037 DEVONSHIRE DR.	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		RAILROAD CLERK	B & O RAILROAD

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
MARTIN JOHN HUEBSCHMAN	CATHERINE WOLFE

19e. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MIRIAM B. SCHECK - DAUGHTER	4037 DEVONSHIRE DR. SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	MOST HOLY REDEEMER	12/28/01	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ B. Keith Lynn CFSP	705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bacterial pneumonia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last	Due to (or as a consequence of): b. old age	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical exeminer?	28. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ C Hand M.D	D50759	12/27/001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)
108 PINEBLUFF RD SALISBURY MD 21801 CHARLES FOLASHADE, M.D.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 27 2001	▶ Penna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARTIN NICHOLAS HUEBSCHMAN

DQ S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 42993

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM RUSSELL HUGHES

2. Date of Death Month Day Year: December 21 2001

3. Time of Death: 1108 M

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-12-2151

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 26, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1020 Turners Lane

10f. Zip Code: 21085

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1935-66

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Military Recruiter

16b. Kind of Business/Industry: U.S. Military

17. Father's Name (First, Middle, Last): John Edward Hughes

18. Mother's Name (First, Middle, Maiden Surname): Mae Anna Boulden

19a. Informant's Name/Relationship (Type, Print): Elsie Hughes - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1020 Turners Lane, Joppa, Maryland 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul's Cemetery

Date: 12/27/01

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Stella A Hughes

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pseudomonac UroSepsis — Due to (or as a consequence of): — Couple of weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation with Rapid Ventricular Rate

Left Lower lobe Pneumonia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D19583

29d. Date signed (Month, Day, Year): December 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANUEL M. VAZQUEZ MD 6 Law Street, Aberdeen, Maryland 21001

State Registrar

31. Date filed (Month, Day, Year): DEC 26 2001

32. Registrar's Signature: Jennifer D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HUGHES, WILLIAM

10+1

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42994

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wayne Anthony Heins
2. Date of Death — Month: 12 Day: 26 Year: 2001
3. Time of Death: 1410
4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-05-7960
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10/24/1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 708 Giles Street
10f. Zip Code: 21078
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Photographer
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: John F. Heins
18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys Anthony

19a. Informant's Name/Relationship *(Type, Print)*: Margaret L. Heins- Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 708 Giles St., Havre de Grace, MD 21078

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harford Mem. Grdns — Date: 12/29/01
20c. Location - City or Town, State: Aberdeen, MD

21. Signature of Funeral Service Licensee: Sylvaine M. Smith
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List *only one* ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)
e. pulmonary embulus — one hour
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
pulmonary mass
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the ceuse(s) end manner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Prashant Shukla MD
29c. License number: D0004805O
29d. Dete signed *(Month, Dey, Year)*: 12/26/01

30. Neme and address of parson who completed ceuse of death (Item 23a) (Type, Print): 319 South Union Avenue Havre de Grace Maryland 21078 Prashant Shukla MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-7129-025

SALVATORE
IANNANTUONO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42995

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Salvatore Gerald Iannantuono

2. Date of Death (Month, Day, Year): DECEMBER 17, 2001

3. Time of Death: 4:22P.M.

4a. Facility Name *(If not institution, give street and number)*: 412 PHILADELPHIA ROAD

4b. City, Town, or Location of Death: JOPPA

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 219-32-9987

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 3, 1936

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 302 Tall Pines Court, Apt. B

10f. Zip Code: 21009

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retirad)*: Printer

16b. Kind of Business/Industry: Photo Engraver

17. Father's Name *(First, Middle, Last)*: Ralph (nmn) Iananntuono

18. Mother's Name *(First, Middle, Maiden Surname)*: Libera (nmn) DiSocio

19a. Informant's Name/Relationship *(Type, Print)*: Wife Dorothy Helen Iannantuono

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 302 Tall Pines Ct., Abingdon, MD 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Rosary Cemetery

Date: 12-21-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceusa (Final disease or condition resulting in death): e. MULTIPLE INJURIES

Due to (or as a consequenca of):

Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last:

b.

Due to (or as a consequenca of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examinar? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidance 6☒ Othar *(Specify)* SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datermined

28a. Data of Injury *(Month, Day Year)*: 12/17/01

28b. Time of Injury: 3:44 P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Driver of auto involved in collision

28a. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: STREET

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 412 PHILADELPHIA ROAD JOPPA, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed *(Month, Dey, Year)*: DECEMBER 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TINY, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 20 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42996

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clayton William Jones
2. Date of Death (Month, Day, Year): December 24 2001
3. Time of Death: 1:41 pm
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 220-32-1276
6. Sex: 1 ☒ M 2 ☐ F
7. Age (If yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 30, 1937
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 802 Outten Road
10f. Zip Code: 21804
10g. Citizan of What Country?: USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: Army
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuben, Maxican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Agent
16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): Clayton W. Jones II
18. Mother's Name (First, Middle, Maiden Surname): Mildred Luppens Taylor

19a. Informant's Name/Relationship (Type, Print): B. Ann Jones/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 802 Outten Road, Salisbury, MD 21804

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Placa of Disposition (Name of camatary, cramatory or other place): Wicomico Memorial Park
Date: 12/29/01
20c. Location - City or Town, State: Salisbury, MD

21. Signeture of Funeral Service Licensee: ▶ Kell R Lowney CFSP
22. Name end Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximata Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. Lung CANCER — 6 months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or es e consequenca of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only ona): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding Investigetion 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowladga, death occurred at the time, date and place, and due to tha causa(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at tha tima, data end place, and due to the causa(s) and mannar stated.

29b. Signature end title of certifier: ▶ Venus Rivera MD
29c. License number: Res - 000
29d. Date signed (Month, Day, Year): December 24, 2001

30. Name and address of person who completed cause of daeth (Item 23a) (Type, Print): Venus Rivera 600 North Wolfe Street Baltimore, MD 21287-9106

State Registrar

31. Dele filed (Month, Day, Year): DEC 27 2001
32. Registrar's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15+1VA DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42997

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura Mae Johnson
2. Date of Death (Month, Day, Year): December 19, 2001
3. Time of Death: 6:45 AM
4a. Facility Name (If not institution, give street and number): 3321 Dublin Manor Road
4b. City, Town, or Location of Death: Street
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-07-5892
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 8, 1915
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Street
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3321 Dublin Manor Road
10f. Zip Code: 21154
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner & Operator
16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): John (NMN) Rice
18. Mother's Name (First, Middle, Maiden Surname): Minnie Bell Montgomery

19a. Informant's Name/Relationship (Type, Print): Linda M. Thomas / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3321 Dublin Manor Road, Street, Maryland 21154

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens
Date: 12-22-01
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: ▶ Stephen A Waugh
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Congestive Heart Failure — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: ▶ AH MD
29c. License number: D34652
29d. Date signed (Month, Day, Year): December 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haskell 2 North Irving Bel Air Maryland 21014

State Registrar

31. Date filed (Month, Day, Year): DEC 20 2001
32. Registrar's Signature: ▶ Denise B Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#26 Per Phy 12/28/2001 **Certificate of Death** HCHD LM Reg. No. 2001 42998

Physician /Medical Examiner | **Funeral Director**

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Stephen Mark Jones			December 17, 2001	3:30 P M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
8849 Trimble Way	Essex		Baltimore Maryland	
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year) / 9. Birthplace (State or Foreign Country)
247-08-8705	1☒M 2☐F	46 Yrs.		Feb. 24, 1955 / South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8849 Trimble Way	21237	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4 Years	Claims Representative	Insurance Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Jones	Mildred Schaffer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Terrie Jones (Wife)	8849 Trimble Way, Baltimore, Maryland 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bayview Crematory	12/19/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Christine L David	Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. liver failure — 6 months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. alcoholic cirrhosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

metastatic cancer of unknown primary, anemia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) — 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. van Egmond MD	D0056307	December 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. van Egmond MD, 4920 Campbell Boulevard, Baltimore, MD 21236

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 28 2001	Jenna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 42999

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS JONES
2. Date of Death (Month, Day, Year): DECEMBER 23 2001
3. Time of Death: 11:55 P.M.

4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF FOREST HILL
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 219-18-0685
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 21, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 120 G Royal Oak Drive
10f. Zip Coda: 21015
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Yaar or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In home

17. Father's Nema (First, Middle, Last): Oscar M. Johnson
18. Mother's Name (First, Middle, Maiden Surneme): Mary Alice Palmer

19a. Informent's Neme/Relationship (Type, Print): William L. Jones (husband)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda): 120 G Royal Oak Drive Bel Air, MD 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Spesutia Cemetery — Date: 12/28/01
20c. Location - City or Town, State: Perryman, Maryland

21. Signature of Funerel Service Licensee: Emmett B. Cargo
22. Name end Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications thet caused tha death. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one ceuse on eech lina. — Approximate Interval Between Onsat and Deeth

Immediete Cause (Final disease or condition resulting in death): a. Advanced Non Small Cell Carcinoma — 15 months
Dua to (or as e consequence of): of Lung

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performad? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to compiation of cause of death? 1☐ Yes 2☑ No

25. Was casa referred to medical examinar? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At homa, ferm, street, factory, office building, atc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, data end place, end due to the cause(s) end manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, daath occurred at the time, dete end place, and due to the ceuse(s) and menner steted.

29b. Signature and litle of certifier: Manuel M. Lazatin MD
29c. License number: D19583
29d. Date signed (Month, Day, Year): December 25, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MANUEL M. LAZATIN MD 8 Law Street, Aberdeen, Maryland 21001

State Registrar

31. Dete filed (Month, Day, Year): DEC 28 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 43000
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Pearl M. Jester	December 27, 2001	4:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1 Colgate Drive, Apt. 609	Forest Hill	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
330-18-8230	1☐ M 2☒ F	85 Yrs.			March 28, 1916	Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Harford	Forest Hill	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1 Colgate Drive, Apt. 609	21085	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade		homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
O.A. Simmons	Mary M. Taylor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Craig Jester/son	209 Wellington Woods Court, Bel Air, Md. 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Bayview Crematory	12/29/01	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PARKINSON'S DISEASE	10 years.
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Due to (or es a consequence of):	
	c. Due to (or es a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia.
Pneumonia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D35012	DECEMBER 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Kevin Lynch M.D. 2 North Ave. Bel Air, Md. 21014.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 31 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,